Horizontal Aggression Among Manitoba General Duty/Staff Registered Nurses: A Descriptive Study

By

Gayle R. Quick, RN BN

A Thesis Submitted to the Faculty of Graduate Studies in Partial fulfillment of the Requirement for the Degree of

Master of Nursing

Faculty of Nursing
University of Manitoba
Winnipeg, Manitoba

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ABSTRACT

Utilizing a self-report survey guided by the critical incident technique (Flanagan, 1954), 500 general duty/staff registered nurses were randomly selected to gather retrospective, descriptive data on the phenomenon of horizontal aggression--a form of workplace aggression that nurses both perpetrate and endure. Nursing is, and always has been, a female dominated occupation with a feminine identity. Horizontal aggression is believed to be a behavioral response to the oppression that women, and by extension nurses, experience in the patriarchal society and the health care system. A conceptual model of women's and nurses' oppression was constructed for use in this study following a review of literature from the domains of nursing, sociology, psychology, and management.

The findings of this study included that targets believed horizontal aggression occurred frequently, that perpetrators had a pattern of behaving aggressively toward other nurses, and that perpetrators chose their targets because they were conveniently available or were estimated to be safe. The majority of targets worked less hours than their perpetrator and were younger and had less seniority as a nurse.

Aggressive behaviors reported by targets were predominately verbal, active, and direct. The most common verbal behaviors were being rude and non-constructive criticism. Targets described a variety of antecedent factors to the aggression they had experienced as well as reasons that they were chosen by perpetrators. Many of these entities supported aspects of the conceptual model. There were a variety of actions taken by targets following an incident of horizontal aggression. The majority of these were passive attempts to cope and/or avoid the effects of horizontal aggression. These effects included negative physical and emotional effects for targets, and negative effects on patient care. This last group of findings indicate that the phenomenon of horizontal aggression is a serious workplace issue for nurses and warrants future study.

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CHAPTER ONE

STATEMENT OF THE PROBLEM

Background to the Problem

Aggressive behavior perpetrated against registered nurses in the workplace is a real and serious issue (Gates, 1995; International Labor Organization [ILO], 1998). Previous studies have addressed verbal, physical, and sexual attacks on nurses from patients and other health care occupations. However, horizontal aggression--aggressive behaviors that one nurse perpetrates against another--has received limited empirical attention despite over 30 years of discussion in the nursing literature.

Significance of the Study

Registered nurses who become targets of horizontal aggression report experiencing emotional discomfort that endured for days, months, and even years (Farrell, 1997; McCall, 1996; Napier Skillings, 1991). This fact alone makes the study of horizontal aggression worthwhile. However, horizontal aggression is believed to have additional negative outcomes, which makes the study of horizontal aggression even more significant.

Horizontal aggression is believed to be a source of workplace stress and job dissatisfaction for nurses as well as an intensifier of other workplace stresses (Nelson,

1995). Authors have made an untested link between nurses experiencing horizontal aggression and these nurses calling in sick, changing shifts, leaving positions, and even leaving the profession to avoid aggressive individuals, to escape hostile work environments, and/or to recover from the effects of a horizontally aggressive incident (Cox, 1991; Farrell, 1997; Napier Skillings, 1991; Nelson; Thomas & Droppleman, 1997). These actions are proposed to have an emotional and economic impact on nurses and to impede their long-term career progression (Cox; Nelson). However, the issues of absenteeism, turnover, and attrition from the occupation are of particular concern to the profession of nursing as a whole as it could be losing or squandering much of its human resource talent and expending money needlessly to replace it (Anonymous, 1986; Duldt, 1981; Napier Skillings).

Horizontal aggression has the potential to impact patient care because the majority of nurses work at the bedside as general duty/staff nurses. In Manitoba, this category of employment describes 77 percent of all nurses registered in the province (personal communication Terry Wilson, MARN Administration Coordinator, 16 September 1998). General duty/staff nurses deliver their services as part of interdependent teams of nursing peers. When one or

more members of the team harbor hostile emotions, and/or are participating in aggressive behaviors, it becomes more difficult to provide high quality patient care in a timely fashion. This difficulty could be related to a waste of time, energy, and resources on aggressive actions and their effects, or it could be related to the direct refusal of peers to assist each other with patient care tasks (Anonymous, 1986; Duffy, 1995; Farrell, 1997; Hilton, 1993; Nelson, 1995;).

Purpose of the Study

Horizontal aggression has only begun to receive empirical attention. The data on this subject is limited to three qualitative studies that took place in the United Kingdom and Australia. All of these studies had small numbers of respondents and none were focused on the phenomenon of horizontal aggression alone. Thus, it is the purpose of this study to increase the empirical knowledge available on this serious nursing workplace issue and to stimulate future studies on the phenomenon of horizontal aggression among nurses. It is hoped that by doing so the well being of nurses, and their patients, can be improved by improving the environments in which nurses practice.

Research Questions

This study surveyed general duty/staff registered nurses throughout Manitoba in order to answer the following research questions.

1. Did these nurses experience horizontal aggression and if so how frequently?

2. What were the demographic factors that described targets and perpetrators of horizontal aggression as well as nurses who believed they had never experienced this type of aggression?

3. What were the contextual details that described incidents of horizontal aggression?

4. What behaviors did targets describe as horizontally aggressive?

5. What factors led to the aggressive behavior targets experienced?

6. Why did targets become targets of horizontal aggression?

7. What action(s) did targets take following incidents of horizontal aggression?

8. What effects did horizontal aggression have on targets?

Definition of Terms

Aggression

Aggression subsumes a large number of responses that vary in type and consequence; however, all include the delivery of a harmful stimulus to another organism (Baron, 1977; Buss, 1961). Buss proposed a six-factor typology that classified aggressive behavior along six dimensions. These dimensions included verbal versus physical, direct versus indirect, and active versus passive. These dimensions are described in the following paragraphs and summarized in Table 1, p. 7.

Physical versus verbal aggression. Physical aggression describes an attack that uses a weapon (gun, club, knife, or other object) or a body part to inflict harm (bite, kick, scratch, trip, injure, and/or kill) on another organism (Buss, 1961). Verbal aggression includes verbal and non-verbal sub-types and describes an attack in which the harmful stimuli delivered are rejection and/or threat (Buss, 1961). Verbal rejection includes five facets: (a) direct dismissals ("get out"), (b) hostile remarks ("I hate you"), (c) non-substantive criticism of an individuals products or possessions ("this work is no good"), (d) derogatory remarks which is non-substantive criticism that extends to the personal attributes of an individual

("This work is no good because you are stupid."), and (e) cursing which is the use of strong, tabooed words that are socially unacceptable (Buss). Verbal threats are responses that symbolize and substitute for anticipatory subsequent verbal and/or physical attacks (Buss).

Direct versus indirect aggression. Direct aggression occurs when a harmful stimulus is delivered directly to another organism who is able to easily identify her aggressor (Buss, 1961). Indirect aggression is subtler and occurs when the target of aggression cannot easily identify her attacker (Buss). This latter form includes verbal examples such as spreading hurtful gossip and physical examples such as setting fire to a neighbor's house. In both examples, the target is hurt indirectly through damage to her feelings, reputation, or possessions (Buss).

Active versus passive aggression. Active aggression is differentiated from passive aggression based on whether the aggressive behavior has an action component. If the perpetrator delivers the harmful stimulus through some action the aggression is active; however, if the perpetrator delivers the harmful stimuli via inaction than the aggression is said to be passive (Buss, 1961).

Table 1. Buss's Typology of Aggression

Factor	Definition
Physical	The perpetrator used a weapon or a body part to inflict harm on the target.
Verbal/ Non-Verbal	The perpetrator used verbal or nonverbal (includes writing) communication to reject or verbally threaten the target's person (body, feelings, reputation), possessions, or products (work). Rejection included dismissal hostile remarks, non-substantive criticism, derogatory remarks, and cursing.
Active	The aggressive behavior required the perpetrator to do something (action component).
Passive	The aggressive behavior required the perpetrator to omit to or to refuse to do something (inaction component).
Direct	The aggressive behavior took place in the target's presence so she could easily identify the perpetrator.
Indirect	The aggressive behavior took place in the target's absence so she could not easily identify the perpetrator.

Horizontal Aggression

There exists no one consistent definition of the concept of horizontal aggression or even agreement on its use. Some nurse authors have used, and continue to use, the term horizontal violence to describe aggressive behaviors among nurses. Fanon (1963) originally coined this term in his work on oppressed group behavior to describe very violent acts, such as murder and rapes, which members of these groups commit against each other. More recently, the term horizontal violence has been softened to horizontal aggression when discussing aggressive behaviors that occur within the nurse workplace. This softening of terminology reflects the fact that while most nurse authors on this subject still believe that oppression is the underlying cause of the aggressive behaviors, the consequences of these behaviors are less severe than the very violent behaviors described by Fanon. Other terms have also been substituted for horizontal violence throughout the nursing literature, and these terms include intragroup aggression, staff-to-staff aggression, lateral aggression, intragroup hostility, staff-to-staff hostility, intragroup conflict, nurse-on-nurse violence, and nurse-to-nurse abuse.

For the purposes of this study, horizontal aggression has been operationally defined as physical, verbal, and

nonverbal aggressive behaviors that one nurse perpetrates, directly or indirectly, actively or passively, against another nurse in the workplace. These same behaviors would be judged as totally inappropriate if they were directed toward a patient or a member of any other group of health care professionals or employees. It is believed that expression of these aggressive behaviors allows the venting of suppressed emotional tension whose direct expression has been blocked by oppressive forces. These forces limit the opportunity and resources (power, status, and prestige) that women/nurses have in the patriarchal society and in the health care system of that society.

Nurse

The focus of this study was horizontal aggression that occurred between general duty/staff registered nurses. Therefore, unless stated otherwise, the term nurse has been used throughout this document to describe registered nurses globally and general duty/staff registered nurses specifically. In addition, only feminine pronouns have been used when discussing nurses and nursing because the profession remains female dominated and because the majority of study respondents were female.

Summary

Horizontal aggression is an enduring yet often-unrecognized form of workplace aggression for nurses. Horizontal aggression has been discussed in the nursing literature for more than thirty years but has only recently received empirical attention. Consequently, little is known about it. The purpose of this study was to address this lack of knowledge by surveying general duty/staff nurses in the province of Manitoba to elicit their descriptions of, and beliefs about, horizontal aggression within the nursing workplace. The next chapter will describe the anecdotal, theoretical, and empirical literature on the subject of horizontal aggression.

CHAPTER TWO

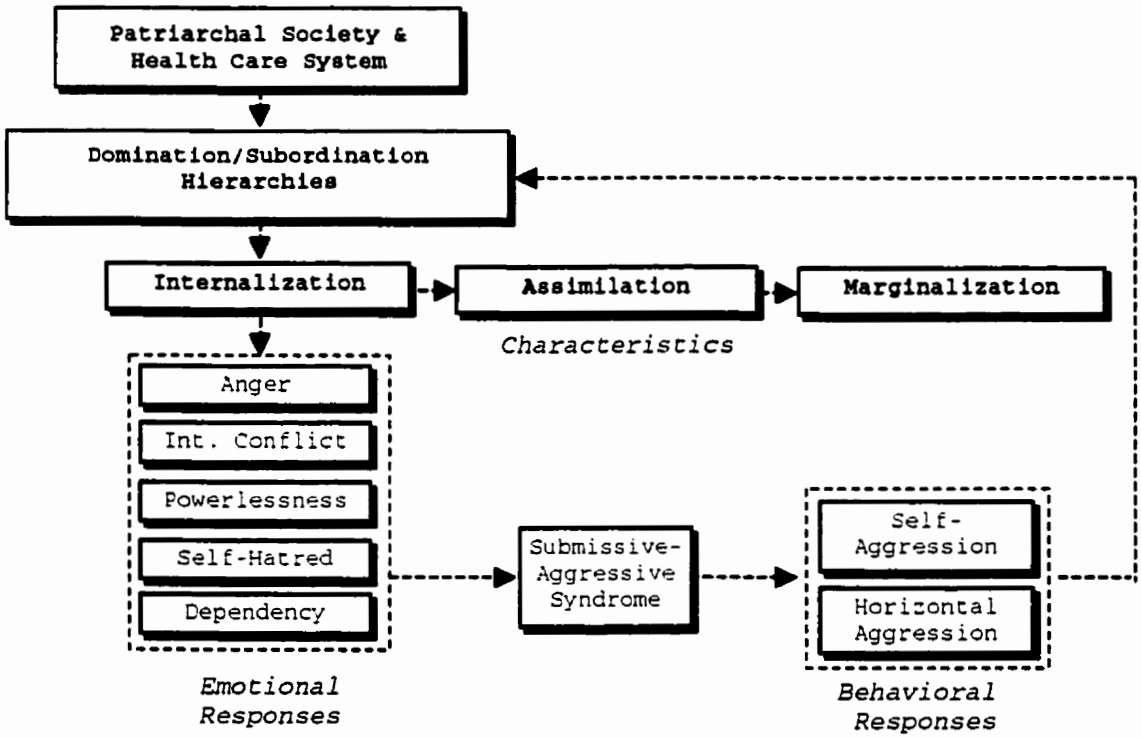
REVIEW OF THE LITERATURE

Introduction

Horizontal aggression among nurses has been talked about within the profession for years, written about in a theoretical and anecdotal fashion since the 1980s, but studied only minimally since 1991. In all cases, the oppression of women was sited as the underlying cause. Nursing has always been a female dominated occupation, and it continues to have a feminine identity. For this reason, authors have linked the oppression of women in society to the oppression of nurses in the health care sector of that society (Buss, 1961; Cleland, 1971; Feminist Press, 1973; Geary Dean, 1988; McCall, 1996; Muff, 1988; Seago, 1993; Spring & Stern, 1998). This focus on oppression of women and nurses to explain the phenomenon of horizontal aggression required that both entities be examined. Thus the review of literature was broad and eclectic and included the domains of nursing, sociology, psychology, and business management. This review highlighted the fact that there existed no conceptual model of women's or nurses' oppression and so one was designed for use in this study (Figure 1, p. 12). This model has been used as the organizing framework for this chapter. It will examine each

concept of the model separately and then conclude with an examination of the limited empirical data available on the subject of horizontal aggression among nurses.

Figure 1. Conceptual model of women's/nurses' oppression



Assumptions of the Conceptual Model

Before discussing the model itself, it is necessary to articulate some of the assumptions and limitations that underwrite the model.

1. This model is being articulated for the first time, and represents an amalgamation of ideas from a variety of authors including this investigator.

2. None of the concepts, or their relationships, has been empirically tested; therefore, all must be treated as hypotheses.

3. Each concept exists on a continuum, and each individual will be affected to a different degree.

4. The model seeks to describe a societal structure at a macro level and is not intended to target specific individuals or groups of individuals.

5. It is accepted that additional and different concepts and interrelations are bound to exist that have not been included in this model.

6. The model is based on the history and function of nurses working in acute and long-term health care facilities. It is accepted that the reality and experiences of community health nurses may or may not be different.

Patriarchy in General Society

Definition

Patriarchy, or "male dominance over women and children" (Spencer, 1990, p.277), has been described as the most common societal structure in the world (Ashley, 1980; Baker Miller, 1986; Barritt, 1984; Buss, 1961; Cleland, 1971; Daly, 1997; Lovell, 1988; Spencer). In this scheme, men have had opportunity and resources and have used them to oppress women (Baker Miller; Daly; Diaz & McMillin, 1995; Spencer, Wilson Schaef, 1992). Freire (1970) defined oppression as the prescription of one group's behavior by another or any situation in which one group hinders another's pursuit of self-affirmation. Patriarchy represents the structure on which all of Canadian society's major institutions, including health care, have been patterned, (Ashley; Cleland; Larsen & George, 1992; Lovell; Passau-Buck, 1988; Wilson Schaef). As such, patriarchy has had, and continues to have, a fundamental impact on the lives of women and men in society.

Origins of Patriarchy

The origins of patriarchy are not fully understood (Spencer, 1990); however, recorded history reveals that men have been dominant (Ashley, 1980; Cleland, 1971; Wilson Schaef, 1992). The rationale provided in the literature for

this domination included: (a) a biological necessity, in which women had to be protected and provided for during childbearing and childrearing, (b) a psychological necessity, in which the biological differences that separate the two genders required that they be positioned differently in the social hierarchy vis-à-vis each other, and (c) a punitive necessity, in which women were made subservient as a punishment in response to male envy at not being able to support or bring new life into the world (Ashley).

How patriarchy was established is unimportant. What is important are the outcomes that this societal structure has had. One such outcome has been the creation of an unjust domination/subordination (D/S) hierarchy.

Domination/Subordination Hierarchy

Patriarchy has operationalized its oppression of women through the creation of a domination/subordination (D/S) hierarchy in which men and things masculine have been considered superior and have been given a dominant position over women and things feminine based on sex and gender roles. Sex, to be female or male, is determined by the chromosomes received from one's biological parents, is unchangeable, and is unaffected by social influence (Riemer Sacks, 1988; Spencer, 1990; Zimbardo, 1988). Gender, to be

feminine or masculine, is a much more complex issue, and it refers to the stereotypical attitudes, behaviors, and characteristics that make up the roles prescribed for women and men in society (Lasky, 1988; Riemer Sacks; Spencer; Zimbardo).

Feminine gender role. The literature reviewed has characterized the stereotypical feminine gender role as that of wife and mother. This role has been bound by familial relationships and has embraced the fundamental belief of love and duty (Baker Miller, 1986; Larsen & George, 1992; Passau-Buck, 1988; Zimbardo, 1988). This role has been predicated on a non-egalitarian ethos in which women labor for others, provide service to others, and are concerned with the bodily needs and comforts of others, but see their own needs and comfort as secondary (Baker Miller; Larsen & George; Lovell, 1981).

For women, work is believed to include those activities that take place in the home and for which there is no remuneration (Lovell, 1981). Caring for the sick and the aged has been included in this work, and it has been assumed that all women possess the ability to do so (Larsen & George, 1992). Work outside the family home has not been considered a part of the feminine role. This type of work has been seen as supplemental. Therefore, women have not

been encouraged to develop a commitment to their career, to have long-term career aspirations, or to relinquish any duties within the home (Baker Miller, 1986; Larsen & George, 1992; Passau-Buck, 1988; Zimbardo, 1988). Competition, power, anger, and aggression have not been considered a part of the feminine role. Thus many women have had no experience in dealing with these issues and often take a covert approach to them (Larsen & George, 1992).

It has been suggested that the feminine identity is developed, maintained, and enhanced by giving and by being labeled innately inferior. It is believed that women do not develop a strong self-identity because they have learned more about men than about themselves (Baker Miller, 1986; Stern, 1996; Wilson Schaef, 1992). It is also believed that the feminine self-esteem is developed, maintained, and enhanced by gaining the approval of, and maintaining a relationship with, men (Baker Miller; Wilson Schaef, 1992). The loss of a man has been equated with the loss of a part of the self. This fear has kept many women from challenging the oppression they face (Baker Miller; Freire, 1970). No matter how much women have achieved in other spheres of their lives, without a relationship with a man other accomplishments can be reduced to meaningless and worthless

(Baker Miller; McNeil Whitehouse, 1991; Wilson Schaef). In this way, women have objectified men, not as sex objects but as marrying objects which is equally dehumanizing (Wilson Schaef).

Throughout the literature, a variety of descriptors have been used to characterize the stereotypical feminine gender. These adjectives have included: altruistic, childlike, contextual, dependent (particularly on men), docile, emotionally expressive, fearful, holistic, illogical, ineffective, intuitive, lacking initiative, lacking intellect, lacking autonomy (independent decision-making and action-taking), moral, nurturing, passive, sinful, subjective, virtuous, vulnerable, and weak (Baker Miller, 1986; Cleland, 1971; Larsen & George, 1992; Passau-Buck, 1988; Wilson Schaef, 1992; Zimbardo, 1988).

Masculine gender role. The literature reviewed has characterized the stereotypical masculine gender role as that of leader/controller. This role has been bound by unequal relationships in which one is either one-up or one-down as compared to others (Baker Miller, 1986; Wilson Schaef, 1992). This role has embraced the fundamental beliefs of competition and independence. It has existed in a non-egalitarian ethos in which the center of focus is the development of the self and one's place in the world (Baker

Miller; Wilson Schaef). The masculine gender role has allowed for service to others, but this service has not come at the expense of the development of the self (Baker Miller).

For men, work has been seen as a valuable endeavor that takes place outside the home. As such men are to have a life-long commitment to work and it is to be of the utmost importance taking precedence over other aspects of life (Baker Miller, 1986; Passau-Buck, 1988; Wilson Schaef, 1992). The masculine gender role equivalent to caring has been healing, with the healer, who is all knowing, never wrong, and god-like, as the active agent (Wilson Schaef).

Power has been a significant concept in the masculine gender role and has two components. The first is power to advance oneself. The second is power to control others and prevent them from acquiring power that could be used to control you (Baker Miller, 1986; Wilson Schaef, 1992). Further, power is believed to exist in a scarcity model. It can never be given away as this would mean that one had less power for oneself (Wilson Schaef). Money has been the embodiment of power (Wilson Schaef).

Authors have described the masculine identity as being developed by accomplishment and being labeled superior. Therefore, men must at all times abhor, deny, suppress,

and/or make masculine any aspect of themselves that could be considered feminine (Baker Miller, 1986). The masculine self-esteem, has been developed, maintained, and enhanced by being assertive and successful in the world (Baker Miller, 1986). Low self-esteem has resulted when men were unable to attain what the patriarchal system demanded of them (Baker Miller).

Throughout the literature, a variety of descriptors have been used to characterize the stereotypical masculine gender. These adjectives have included: active, aggressive, analytical, autonomous, brave, deductive, effective, freedom-loving, good, independent, initiative, intelligent, leading, linear thinkers, logical, non-paradoxical, objective, physical, powerful, rational, responsible, sexual, strong, unemotional (Baker Miller, 1986; Cleland, 1971; Larsen & George, 1992; Parents try, 1988; Passau-Buck, 1988; Wilson Schaef, 1992; Zimbardo, 1988).

Socialization of gender roles. Authors have indicated that individuals learn their appropriate gender roles through the process of socialization (Baker Miller, 1986; Lasky, 1988; Lovell, 1988; Riemer Sacks, 1988; Spencer, 1990; Zimbardo, 1988). This process begins at birth, with comments such as "she's so cute" and "he's so strong", and continues throughout the lifespan through contact with

significant social institutions (the family, schools, work, and the media) and through imitation of significant others (parents, siblings, teachers, bosses, and peers) (Riemer Sacks; Spencer; Zimbardo). Socialization has sought to maintain appropriate gender roles by rewarding compliance and punishing noncompliance. Punishing actions designed to encourage women to act out the feminine gender role have included: (a) social ostracization and isolation, (b) threat of abandonment, (c) threat of not having a close relationship with a man, and (d) even verbal and physical abuse (Ashley, 1980; Baker Miller; Freire, 1970; Larsen & George, 1992; Lovell, 1988; Muff, 1980; Wilson Schaef, 1992).

Outcomes of the D/S hierarchy. The D/S hierarchy has resulted in situations in which women and men have experienced life differently. Opportunities for women have been limited; opportunities for men expanded; and resources (power, status, and prestige) unequally distributed (Baker Miller, 1986; Cleland, 1971; Cox, 1991; Duffy, 1995; Freire, 1970; Keen, 1991; Larsen & George, 1992; Passau-Buck, 1988; Roberts, 1983). Opportunities have included the opportunity to grow, develop, and change; to acquire knowledge and skills; to advance within one's career; to be challenged; and to act independently (Kanter, 1977, 1993).

Thus, the outcomes of the D/S hierarchy have been inequality and injustice, which have been maintained by control myths and fears (Duffy; Hedin, 1986; Keen; Muff, 1988; Roberts; Spring & Stern, 1998; Wilson Schaef, 1992).

Control Myths and Fears

Hedin (1986) defined control myths as collective beliefs that although not based on evidence are tenaciously clung to. Control myths have been designed to prevent women from challenging the status quo of their oppression. These myths are predicated on the very real fear that if women were to do so it would bring about a change in the patriarchal structure and men would loose their dominant position and the subservience of women (Ashley, 1980; Keen, 1991). Control myths have been perpetuated and justified by the patriarchal social order through evidence it has produced via its ability to determine the culture's philosophy, morality, social theory, and science (Duffy, 1995; Hedin; Keen; Muff, 1988; Roberts, 1983; Spring & Stern, 1998; Wilson Schaef, 1992). Control myths have become ideologies and have been followed by action, policy, and the formation of laws and social institutions. These entities have reflected the patriarchal biases about women and men, perpetuated these biases, and justified the inequalities that exist for both genders in society

(Ashley; Baker Miller, 1986; Shainess, 1988; Wilson Schaef). The literature reviewed yielded 10 control myths as described below and listed in Table 2 (p. 29). Many of these myths appear contradictory, even illogical when positioned next to others. However, as Wilson Schaef pointed out, this is evidence of the illogical and untrue nature of control myths in general.

Women as ultimate evil. In this control myth, women have been portrayed as the source of all evil, untrustworthy, and incapable of controlling their destructive emotional impulses (Ashley, 1980; Baker Miller, 1986; Larsen & George, 1992; Muff, 1980). Muff described this as the prototypical control myth of patriarchy from which all others are derived and which continues to sanction cruel and unjust treatment of women. This control myth has been operationalized in the biblical story of Eve who tempted Adam in the Garden of Eden and in the mythological story of Pandora who let loose all the ills and suffering on humanity (Ashley). This control myth seeks to reduce women to nothing more than a necessary evil for continuation of the species (Muff).

Paternalism as divinely granted. This control myth has sought to link the patriarchal structure to divine intervention. This control myth has been evident in the

teachings of many religions, including Christianity. These teachings have described men as the original, autonomous human persons created first in God's image and to do his work. Women have been described as derivative beings, created second, and to work for men (Ashley, 1980; Muff, 1980). These same ideas have formed the basis of Western philosophy. In this philosophy, women have been perceived as defective, inferior, and requiring male intervention to restrain their natural destructive tendencies. Further, it has been espoused that this restraint should be accomplished via servitude to a male master for whom a woman lives to please and for whom she toils tirelessly in the shadows making him great and interacting with the world vicariously through him and his male offspring (Ashley).

This myth prevents women from challenging the inequality of patriarchy, based on the fact that if paternalism is divinely granted then it is morally wrong and a sacrilege to challenge or attempt to change it (Ashley, 1980; Baker Miller, 1986; Freire, 1970; Keen, 1991; Lovell, 1988; Roberts, 1983; Wilson Schaef, 1992).

Super men and their super roles. In this control myth, the male sex has been seen as genetically superior to the female sex, and by extension the masculine gender role has been seen as more important and of more value than the

feminine role (Ashley, 1980; Baker Miller, 1986; Freire, 1970; Wilson Schaef, 1992). This control myth was championed by Freud, and later by neo-Freudian psychologists such as Maslow, who described women as biologically defective owing to their absence of male genitalia (Lovell, 1988; Wilson Schaef). This type of thinking has left women with a deep-rooted inferiority complex based on a biological characteristic they cannot control or change. This control myth has maintained the status quo of oppression by making women doubt their ability to survive or thrive without patriarchal supervision and control, or to even fear having that eventuality (Ashley; Baker Miller; Freire; Roberts, 1983; Wilson Schaef, 1992).

Paternalism as a duty. Linked to the above control myth of male superiority, this control myth has justified paternalistic treatment of women by acknowledging it as a necessity and a duty based on the inherent weaknesses of the female sex. It has even suggested that women should feel gratitude towards men for their self-sacrifice (Ashley, 1980; Baker Miller, 1986; Freire, 1970; Lovell, 1988; Roberts, 1983). This control myth like the one before has delayed women from recognizing their oppression and actions to change the status quo (Baker Miller; Lovell).

Society exists in a descending hierarchy. This control myth has justified the existence and maintenance of the D/S hierarchy previously discussed. This myth has suggested that society can only exist in a descending hierarchy composed of god, men, women, children, animals, and the earth (Wilson Schaef, 1992). Those higher in the hierarchy are assigned more opportunity and resources; and therefore, have more ability to dominate and control those below them, which is accepted as the common practice (Hedin, 1986; Wilson Schaef). It is assumed that one should constantly strive to move upward in the hierarchy and that this is best accomplished by assimilating the beliefs and imitating the actions of that entity whom is one rung above (Wilson Schaef).

Hear no evil see no evil. In this control myth, inequality between the genders has been denied, and women have been encouraged to believe that they can achieve the same things as men simply by working hard (Baker Miller, 1986; Freire, 1970; Hedin, 1986). This myth has denied the inequality of opportunity and resources that exist between women and men.

Women as objects. In patriarchy, the term "man" has been used synonymously for human being, and masculinity is the model on which all things have been interpreted,

defined, measured, directed, and evaluated (Baker Miller, 1986). This control myth has allowed society to think of and treat women as objects and possessions rather than human beings because women are not men or masculine (Freire, 1970; Keen, 1991; Stern, 1996). This myth has justified the idea of female servitude and unjust or even cruel treatment of women (Ashley, 1980; Stern). This control myth has encouraged women and men to dismiss the entire concept of inequality between the sexes by dismissing one entire gender.

All concepts exist as a duality. In this control myth, the entire world can be described in terms of an either/or duality rather than a continuum. In keeping with this myth, there are only two possible options on any given issue--right or wrong, black or white, good or bad, virtuous or evil, true or false, up or down, superior or inferior, feminine or masculine. (Baker Miller, 1986; Muff, 1980; Wilson Schaef, 1992). This control myth has made no allowances for a middle ground, so if one supports one side of the duality it automatically means one does not support the other and visa versa (Wilson Schaef). This control myth has fed the fear of the patriarchy that if men were to loose their dominant positions in society their only option would be inferiority and subordination (Baker Miller).

Men know everything - women nothing. This control myth stems from the fact that the patriarchal society has dictated what is to be known, how it is to be known, and whether the knowledge has value (Wilson Schaef, 1992). This control myth has resulted in many women looking outside themselves and past other women to men for advice and direction. This myth has led both genders to believe that men should know it all and if they don't there is something wrong with them (Wilson Schaef).

Men as god-like beings. In this control myth, men are led to believe that they can be god-like by controlling the universe through the development and use of technology, by ensuring their immortality through the production of male offspring, by amassing material wealth, and/or by producing or amassing lasting items such as art and literature (Wilson Schaef). This myth has resulted in the devaluing or even ignoring of anything that could not be measured, predicted, or controlled.

Table 2. Control myths of patriarchy in society

1. Women as ultimately evil.
2. Paternalism as divinely granted.
3. Supermen and their super roles.
4. Paternalism as a duty.
5. Society exists in a descending hierarchy.
6. Hear no evil--see no evil.
7. Women as objects.
8. All concepts exist as a duality.
9. Men know everything--women nothing.
10. Men as god-like beings.

Socialization of control myths. Control myths have been internalized through socialization and they now operate at a subconscious level to exert a very strong influence on both women and men in our society (Ashley, 1980; Larsen & George, 1992; Muff, 1980; Wilson Schaef, 1992). Many of these control myths may be hard to accept, and both women and men may believe that these myths no longer exist or no longer exert an influence. This in fact is untrue. As with patriarchy, control myths have been with us since the beginning of time (Muff), and their core messages have never died or even faded away (Shainess, 1988; Wilson Schaef). Instead, these messages have been

repackaged so they remain palatable in modern times and are able to exert a continuing influence (Larsen & George).

Control myths, along with the stereotypical gender roles, have formed a popular image of women and men, which although false, continues to be believed at some level. This image has influenced the behaviors of women and men and developed the attitudes they hold toward each other and the world.

Patriarchy in the Health Care System

Definition

The health care system that we know today was created in the latter part of the 19th century and was built on, and influenced by, the patriarchal structure of general society. In this structure, the two major occupational groups--nurses and physicians--have become gender dominated, and have adopted patterns of behavior similar to those that existed between women and men in general society (Larsen & Baumgart, 1992; Lovell, 1988; Passau-Buck, 1988; Stuart, 1994). Nursing is, and always has been, a female dominated occupation and as such has, and always has had, a feminine identity (Kutlenios & Bowman, 1994; Larsen & George, 1992). Medicine, on the other hand, is, and always has been, a male dominated profession and as such it has, and has always had, a masculine identity (Kutlenios &

Bowman; Larsen & George). In Manitoba, the number of male nurses is approximately four percent while the number of female physicians is about 25 percent which is in keeping with the Canadian averages (Marianne Hodgeson, Registrar, Manitoba Association of Registered Nurses, 21 October 1998; Ian Foster, Canadian Medical Association Manitoba Branch, personal communication, 19 October, 1998). So, while it is true that each profession has practitioners of both genders, neither group is sufficiently diverse to alter its historic gender identity or to escape the impacts of the stereotypical gender roles, control myths, and fears that impact women and men in general society. Further, the strong gender identity of each profession is believed to exert its influence on all members of the occupation regardless of the gender of individual nurses and physicians (Chinn, 1980; Cleland, 1971; Donner, 1992; Larsen & George; Muff, 1980; Watson, 1990).

Origins of Patriarchy in Health Care

Like general society, the health care system has been organized in accordance with the patriarchal model. This model had a major influence on the development of the professions of nursing and medicine as is illustrated by the historical roots of each profession.

History of medicine. Until the 13th century, health care was provided solely by female and male lay healers. These healers practiced curing and caring, were valued for both, and had at their disposal a host of pharmaceutical and other treatments based on a body of experiential knowledge (trial and error) handed down through the ages (Muff, 1980; Stuart, 1994). The profession of medicine began in 13th century Europe as a secular science sponsored by the ruling-classes and strictly controlled by the church. Practitioners were male, upper class, and university trained. Once educated, these practitioners offered their services only to patients who were in the upper or ruling classes. Medical education of the day focused predominantly on philosophical and theological theories, did not include interaction with patients or laboratory work, and was separated from surgery, which was equated with the manual labor of a butcher. On completion of training, physicians had little to offer patients beside quasi-religious, superstitious rituals such as bleeding and watering.

Following its inception, medicine set about on an organized campaign; backed by the ruling class and the church, to eliminate lay healers. They did so first by barring lay healers from the universities, then by

outlawing their practice, and finally by being the "expert witnesses" to their guilt in the witch-hunting trials. Thus, physicians were able to establish a monopoly over the right to cure, were able to deprive a host of lay healers of their livelihood, and were able to prevent the majority of the population from having access to quality health care (Feminist Press, 1973).

In North America, a similar takeover of lay healing and midwifery began in the 19th century by the upper-class male medical profession (Aaronson, 1989; Feminist Press, 1973). As in Europe, the elimination of female healers was a consorted effort by the American Medical Association backed by the state and business elite. This takeover represented a class, race, and gender struggle for power and the right to make money from health care. In the beginning, these North American physicians also had little to offer patients still depending on rituals such as bleeding, large doses of laxatives, and opium (Feminist Press). In 1910, the Flexner Report established the current pattern of medical training. It also closed two-thirds of the physician training establishments in the United States and Canada because they did not achieve accreditation and ended the careers of practicing physicians who did not have the prescribed education because the report did not contain

a grandfather clause. Many of these latter physicians were female, non-Caucasian, and not from the upper class (Aaronson; Feminist Press; Stuart, 1994). The results of the Flexner report instilled medicine's professional authority (each practitioner was imbibed with the authority of the group), and allowed the profession to control its education and limit the number of physicians produced (Aaronson). These actions allowed the profession of medicine to maintain a scarcity of practitioners, which increased the value attached to medical services and created a homogeneous and cohesive group. Both of these actions allowed medicine to acquire and maintain political power (Aaronson; Stuart) and allowed medicine to develop a monopoly on health care. This monopoly meant that patients had no choice but to seek advise from physicians, if they could afford it, and were forced to receive health care in institutions, where physicians worked, and not in their own homes (Boutilier, 1994; Stuart). Thus, the health care industry was created. An industry in which physicians had the majority of power, status, and prestige and medicine was able to exercise its uncontrolled mandate of professional authority into areas for which many practitioners had no formal training or legitimate claim to expertise such as delivering infants (Boutilier; Stuart).

In addition, this industry broadened the scope of medical practice so that it controlled public access to most health-related goods and services including nursing (Aaronson).

Many of the health care reform initiatives being proposed and initiated in today's health care sector recognize the mal-distribution of resources toward medicine and acute care facilities; however, to date action to change this reality has been limited. Thus, the historical roots of medicine have resulted in a popular image of physicians as powerful, white, male, upper-class practitioners with a monopoly on health care and the dominant position in health care.

History of nursing. While some authors make a link between lay women healers and nursing (Dodd & Gorham, 1994), in reality, the profession of nursing was created in the latter half of the 19th century during the Victorian era. The "modern" physicians of the time needed a subservient workforce that would provide care and implement the "dirty" work of cure by following medical orders (Boutilier, 1994; Stuart, 1994). Prior to this period, nurses were often described as non-respected, untrained, female, working-class laborers of questionable social morals who had to work in the squalor of charity hospitals

that served the destitute and the insane in order to earn a meager living (Boutilier). Florence Nightingale, along with other wealthy patron reformers, transformed this sullied image into something new and better by linking nursing to the new and now prestigious medical profession. Thus nursing became a respectable, middle-class occupation for women from good families, with high moral virtues. These women were expected to be educated and trained and yet remain subservient to physicians. It was expected that nurses would toil selflessly in the splendor of the new, modern hospitals created and dedicated to the scientific medical model in order to serve a higher calling (both God and physicians). While their pay was low, and their working conditions difficult, being a nurse became an avenue to acquire and utilize the same skills required to be a wife and mother (Boutilier; Lovell, 1988; Feminist Press, 1973). The transformed nursing occupation, and its education, was under the control of medicine, and as the number of hospitals increased so did the number of nursing schools and the number of nurses produced to meet the rapidly increased demands (Aaronson, 1989; Boutilier). Nursing was not able to achieve autonomy over its practice. Instead, nursing became structurally dependent on medicine in a network of nested differentiation in which nursing

delivered its services to patients for physicians (Aaronson; Boutilier; Roberts, 1983; Stuart).

Unlike medicine with its monopoly on cure, nursing was not able to create a monopoly on care-giving. Instead, a stratified hierarchy of caregivers using the term "nurse" was created. This hierarchy included registered nurses, practical nurses, registered psychiatric nurses, nurse practitioners, nurse clinicians, nursing assistants, nursing aids, and more. Within this hierarchy, registered nurses created other hierarchies that further divided this group along the lines of education, ideology of practice, and the location of practice. These divisions included diplomas versus university degrees, research based versus tradition, practice versus education versus administration; professionalism versus unionism; staff versus management; specialist versus generalist; critical care versus non-critical; and institution versus community (Aaronson; Boutilier; Duldt, 1981; Geary Dean, 1988; Larsen & George, 1992; Oaker & Brown, 1986; Spring & Stern, 1998; Stein, 1967; Stuart, 1994). This amount of divisiveness contributed to a lack of cohesion and organizational power within the nursing profession, and left it vulnerable to divide and conquer strategies by the better organized, more politically astute and connected, and more cohesive medical

associations (Aaronson; Boutilier; Geary Dean; Larsen & George; Stuart; Stein).

Thus, the historical roots of nursing have resulted in a popular image of nurses as a female, middle-class laborer whose interventions paralleled the domestic work of women in the home and whose position in the health care sector was subordinate to physicians.

History of nursing's oppression. There remains much debate over how far the professions of nursing and medicine have migrated from their historic roots. What is certain, is that these roots continue to impact the behavior of individual practitioners and their interactions with members of their group, with other professions, and with the patients they serve. Until the 1980s, nurses seemed to be unaware, or at least inactive with respect to its oppression. This changed in the early 1980s on the heels of the women's movement of the 1970s. At this time, nurse authors began to label nursing as an oppressed group and expanded the concept of oppression of women in the patriarchal society to include the oppression of nurses in the patriarchal institutions of health care. Like oppression of women in general society, oppression of nurses is described as including a D/S hierarchy and is maintained by control myths and fears.

Domination/Subordination Hierarchy

A vast number of authors have described physicians and medicine and nurses and nursing as existing in a domination/subordination (D/S) hierarchy within the health care system. This hierarchy has been described as analogous to the D/S hierarchy that exists for men and things masculine and women and things feminine within general society. In the health care D/S hierarchy, physicians and medicine have been considered superior, and therefore have been given a dominant position and increased societal value over nurses and nursing. The positioning of the two professions has been based on the gender identity of each profession, which has dictated stereotypical occupational roles for its practitioners. These roles have been adapted from, and are extensions of, the societal gender roles discussed earlier in this chapter. The literature reviewed yielded nine stereotypical occupational roles for nurses and physicians as described below and listed in Table 3 (p.51).

Physicians cure--nurses care. This first occupational role has often been referred to as the cure/care dichotomy. This role separates all of health care into two mutually exclusive and dichotomous entities. Cure has been seen as the unifocal concept of the medical model, as synonymous

with health, and as the domain of physicians' alone (Dodd & Gorham, 1994). This linking of cure to medicine has given cure a masculine, hard-hitting image that has made cure seem to be the most important value to society; therefore, requiring the lion share of health care funding (Muff, 1980; Passau-Buck, 1988; Stuart, 1994; Watson, 1990). It has been assumed that cure requires vast amounts of knowledge and skills that have been gained through an advanced, scientific education obtained in a university setting. It has also been assumed that the practitioners of cure deserve a high level of remuneration (Passau-Buck).

By contrast, care has been seen as a multi-focal concept with nebulous scientific ties, as synonymous with the feminine gender role, and as the domain of nurses' alone (Passau-Buck, 1988). This linking of care to nursing has given care a feminine, soft image that has made care seem to be a secondary subset of cure and of less importance and value to society. Therefore, care is believed to require less health care funding (Aaronson, 1989; Kutlenios & Bowman, 1994; Muff; Passau-Buck; Stuart, 1994; Watson, 1990). It has been assumed that care requires no specialized or scientific knowledge; therefore, its practitioners require only a minimal level of remuneration (Passau-Buck).

In the past two decades, thinking around the structure and function of health care, and its funding, have resulted in a number of reforms designed to incorporate broader determinants of health and to encourage a collaborative approach among health care practitioners (Evans et al., 1994). These initiatives have resulted in many nurses, physicians, and patients no longer believing the basic edicts of the cure/care dichotomy. Yet, these stereotypical roles have continued to insert their influence on the behavior and attitudes of nurses, physicians, the public, and politicians (Lovell, 1988). Nursing and medicine are both important health care entities. Both professions are essential and neither needs to be sacrificed for the other (Watson, 1990; Evans et al.).

Nursing as blue-collar labor. Nursing has developed to the point where its interventions are vast and vastly different. At one moment nurses can be involved in complex and highly technical interventions with the potential to cause harm and during which they must make life and death decisions. At another moment, these same nurses can be engaged in socially defined domestic, dirty, trivial, and menial tasks such as bathing, feeding, walking, talking with patients; emptying bedpans; changing linen, etc.

Unfortunately, this latter group of interventions has often formed the sum total of the popular image of nursing work and has allowed nurses to be portrayed as semi-skilled, blue-collar laborers (Dodd & Gorham, 1994; Duffy, 1995). This misconception has often resulted in decisions to replace nurses with under-trained and unlicensed health care workers (Gordon, 1995). This misconception has also allowed physicians to feel justified in delegating work to nurses and then disappearing. Thus, physicians have escaped the time-consuming and often "dirty" work associated with medical interventions. They have kept their professional domain unifocal, easily defined, and clearly bounded. They have also ensured that the public image of their work, in contrast to nursing's work, has been that of the "white-collar" professional (Dodd & Gorham; Stuart, 1994).

Nurses only work at the bedside. In this stereotype, the sum total of nursing is believed to be those activities that take place at the patient's bedside. While these activities are important, they do not describe the sum total of nursing work. This stereotypical role has given no credence to many other important aspects of nursing, including community health, education, research, and administration. Nursing research, for example, has often been devalued, and has often been viewed as a secondary

duty to be done only if and when the "real nursing" at the bedside was finished. This secondary positioning of research has resulted in a reduction of resources available for nursing research projects and a retardation in the advancement of nursing's theory base and body of knowledge (Muff, 1980).

This stereotype has also made nursing education a contentious issue for nurses, the public, and facility administration. Nurses and the public are often operating on a false premise that nurses with higher education will not be involved in care. Facility administrators are often hesitant to support higher education or advanced nursing roles as they fear this will necessitate a change in the current scheme of nursing remuneration (Kalisch & Kalisch, 1988).

This stereotype has also been used by nurses, physicians, administrators, and patients to justify criticism of nurses who have chosen to participate in actions aimed at advancing the profession (higher education or advanced practice roles) by suggesting these nurses were abdicating their primary responsibilities at the bedside or trying to be physicians (Kalisch & Kalisch, 1988; Stein, Watts, Howell, 1990). This criticism has often been displayed in comments such as "if you want to be a doctor

go to medical school" (Kalisch & Kalisch) or patronizing comments about advanced education and practice roles. It is believed that these comments are donned out of a fear among the medical profession that nurses will become a competitive force and physicians will lose a skilled worker to carry out their orders (Kalisch & Kalisch; Lovell, 1981; Lovell, 1988; Dodd & Gorham, 1994).

The physician as god. The stereotypical role of the physician as god-like began at a time when new scientific and technological advances allowed physicians to achieve terrific patient outcomes by using revolutionary pharmaceutical and/or surgical interventions. This stereotype has been perpetuated by medical school socialization during which a sense of omnipotence has been instilled into fledgling doctors to allow them to overcome the very realistic fear of making errors that could end a patient's life (Kalisch & Kalisch, 1988). This omnipotence, however, has often been carried over into the interactions physicians have with others. The fact that physicians have often been different than these other individuals with respect to income, social class and status, educational levels, gender, and nature of tasks performed has further supported this stereotype (Duffy, 1995). These differences have often resulted in physicians being treated with

deference within the health care system and allowed, or even encouraged, physicians to adopt the dominant "captain of the ship" role (Kalisch & Kalisch; Lovell, 1981). While some nurses believe that physicians still see themselves as god-like, other authors have described the public esteem for physicians deteriorating. This deterioration has been described as resulting from a number of issues. The first issue has been the commercialization of medical care, which has undermined the public's confidence in the profession's devotion to altruism. The second issue has been the increased use of specialist consultation making it obvious that one physician can no longer be all things medical for all patients (Larsen & Baumgart, 1992; Lovell; Stein, Watts, Howell, 1990). Other issues could include the increased sophistication of patients with respect to their health and their rights, and the impact of negative media reports including physician negligence, physician's refusal to work outside of urban areas, and funding disputes in which physicians withhold services or work to rule.

Nursing equals a mother's TLC. In this stereotype, the nursing role has been seen as a natural extension of the role of the mother who delivers tender loving care (TLC) to her child-like patients (Feminist Press, 1973). This stereotype was clearly displayed in a 1994 NBC Nightly News

program story about the layoff of 20-50 percent of nurses and their replacement with unlicensed aids. The news anchor introduced the segments as "A new and controversial way to administer TLC" as if the only outcome of the loss of this many nurses was a reduction in TLC (Gordon, 1995). Gordon goes on to say:

> "Imagine how the issue would be characterized if 20 to 50 percent of staff physicians were eliminated in thousands of American hospitals. Would it not be front-page news, a major public-health catastrophe? Patients all over the country would be terrified to enter hospitals…Nursing is not simply a matter of TLC. It's a matter of life and death." (p. 86).

This control myth, that nursing is nothing more than TLC, has downplayed the important and pivotal role nurses play in health care, has dismissed the fact that today's nurses are highly educated and highly skilled, and has denied the specialized interventions that nurses provide (Larsen & George, 1992; Lovell, 1988; Watson, 1990). This control myth has also been used to justify issues such as early discharges in the mistaken belief that much of convalescent care is unskilled work that any woman can do in the home (Dodd & Gorham, 1994). This initiative has increased the burden on patients and their family members, particularly

women, who are expected to take on this caring as a part of their gender role.

Token torturer. In this stereotype, nurses are depicted as the health care provider who inflicts pain and suffering. However, this pain and suffering is most often an outcome of the interventions ordered by physicians who are able to remain distant from patients and the pain their interventions have caused (Ashley, 1980; Muff, 1980). Ashley went on to discuss that when physicians directly inflict pain and suffering on patients, it is often during the acute phase of the patients health care event when these patients are under anaesthetic, unconscious, or in shock. Therefore, patients often do not remember the pain and suffering they experienced at their physician's hands. By contrast, nurses inflict pain and suffering on patients during their recovery period when patients are awake and able to remember the details. This may account, in part, why patients have remembered their physicians as creating miracles from afar, but associated their nurses with a period of their life that was full of pain, anxiety, uncertainty, and a loss of control (Ashley; Gordon, 1995; Muff, 1980).

Nurses work under the close supervision of physicians. In this stereotype, nursing has been considered a subset of

medicine, and nurses have been considered subordinates who work for physician bosses. This stereotype depicts nurses as silently and blindly following the orders of a physician master without thinking for themselves or independently devising a plan of care (Boutilier, 1994; Feminist Press, 1973; Stuart, 1994). This stereotype ignores the fact that nursing now includes independent duties and responsibilities, specialty-trained and certified advanced practitioners, and research-based interventions (Larsen & Baumgart, 1992; Larsen & George, 1992; Passau-Buck, 1988; Stein, 1967). Further, this stereotype has slowed the momentum toward autonomous nursing practice (Muff, 1980). The opportunity to practice autonomously has always been important to physicians, and they have always defended their independence and right to control and speak for the practice of medicine (Kalisch & Kalisch, 1988). However, nurses have not been afforded these same rights. Many physicians and health care administrators believe they have a right to exert some control over nursing practice and/or are justified in speaking for nursing with the media, with politicians, and within the governance structure of the health care system (Kalisch & Kalisch). This practice has robbed nurses of their voice, has added to the invisibility of nurses within the health care system, and has exploited

nurses by stymieing their actions to achieve accountability for nursing practice (Duffy, 1995; Roberts, 1983).

A nurse is a nurse is a nurse…. It is a commonly held belief that all nurses do exactly the same work and that nurse A can easily be replaced by nurse B. This stereotype has endured despite the fact that different areas of nursing have become vastly different from each other with respect to the age, acuity, and length of stay of patients; the complexity of diagnoses and treatment; and the type of technology used (Larsen & Baumgart, 1992). This stereotype has completely disregarded the fact that nurses build expertise and become experts in these different areas of nursing by acquiring specialized knowledge and skills. Thus, this stereotype has ignored the fact that these experienced and expert nurses are valuable employees and difficult to replace.

This stereotype has been used to justify the floating of nurses to areas where they were not experienced and not comfortable working (Larsen & Baumgart). This stereotype has also prevented serious action aimed at decreasing the high turnover rates among nurses. Rather, the traditional response has been to increase enrolment rates ignoring the fact that newly graduated nurses cannot easily replace those with experience and expertise (Larsen & Baumgart).

Nurses do any task others don't want to do. In this stereotype, the nurses' role is assumed to include all tasks except those that are the exclusive purview of physicians. This stereotype has often justified the reduction or deletion in the number of personnel employed in direct support of nurses (orderlies, practical nurses, and aides) and in other departments that impact patient care (dietary, housekeeping, clerical, pharmacy). In making these downsizing decisions, administrators have assumed that nurses would, and should, take over these duties (Larsen & Baumgart, 1992; Passau-Buck, 1988). Many nurses have done so to ensure that their patients have remained safe and comfortable; however, by doing so, these nurses have unwittingly supported this stereotype (Larsen & Baumgart, 1992). Further, this stereotype has resulted in a situation in which it is almost impossible to define the unique domain of nursing practice because the boundaries of this domain have remained unclear. This situation continues to hamper nurses from obtaining complete autonomy over their practice (Kalisch & Kalisch, 1988). This stereotype has also worked in tandem with the stereotype of nurses as semi-skilled, blue-collar workers making it more difficult for nursing to be recognized as a profession.

Table 3. Stereotypical occupational roles

1. Physicians cure--nurses care.
2. Nursing as blue-collar labor.
3. Nurses only work at the bedside.
4. The physician as god.
5. Nursing equals a mother's TLC.
6. Token torturers
7. Nurses work under the close supervision of physicians.
8. A nurse is a nurse is a nurse.
9. Nurses do any task that others don't want to do.

Socialization of occupational roles. Occupational roles have been prescribed by society and are learnt by nursing and medical students through the process of professional socialization (Donner, 1992; Duffy, 1995; Kutlenios & Bowman, 1994; Roberts, 1983). This socialization begins when nurses and physicians enter formal education programs, continues through their orientation to the occupation, and concludes when personal integration into the occupation is complete (Briles, 1994; Donner; Duffy). Once socialized, occupational roles are believed to exert a strong influence on the behaviors and attitudes of members of a profession and their view of

themselves and their position, rights, and responsibilities in society (Donner; Muff, 1980).

Outcomes of the D/S hierarchy. The health care D/S hierarchy has been described by a large number of authors as resulting in physicians and medicine being assigned greater amounts of opportunity and resources than nurses and nursing. Thus, medicine has come to be known as a controlling, exploitive, and oppressive force for nurses and their practice.

Control Myths and Fears

A large volume of the literature reviewed described paternalistic control myths and fears as permeating the health care system. These authors indicated that these myths and fears have served to maintain the oppression of nurses in this system. These control myths and fears have been built on the control myths and fears about women and men that exist in the general patriarchal society. The myths that exist in the health care system, along with the stereotypical roles of nurses and physicians, have formed the enduring popular image of these two groups. This image has influenced the attitudes and behaviors of nurses and physicians, and it has colored the impression the public and politicians hold of both occupations (Muff, 1980). The literature reviewed yielded six control myths as described

below and listed in Table 4 (p. 59). Like the patriarchal control myths and fears discussed earlier, many of these myths and fears appear contradictory, even illogical when positioned next to others. Many of these myths are hard to accept by both professions who may believe that these myths no longer exist or no longer exert an influence. This in fact is untrue. Their outer packaging may have changed, but the myths themselves live on.

Nurses as angels of mercy. In this control myth, nursing has been seen not as a profession or even a job, but rather as a religious calling. In this myth, nurses have been portrayed as selfless and self-sacrificing nun-like beings that toil without complaint or request for remuneration because she has a calling to serve a higher purpose (Larsen & George, 1992; Muff, 1980; Passau-Buck, 1988; Watson, 1990; Wilson Schaef, 1992). This control myth has encouraged nurses to put the needs of patients, physicians, and everybody else above their own and even to their own detriment (Muff). This myth has also deterred nurses from assertively fighting the oppression they face or for better salaries, benefits, and working conditions as these activities have been portrayed as un-nurse-like and as violating some fundamental principle to which nurses should aspire (Duffy, 1995; Feminist Press, 1973; Hedin,

1986; Larsen & George). As Larsen & George stated, "nursing ideology is based on a women's duty not on a women's rights" (p. 75).

Physician, nurse, and patient as a patriarchal family. In this control myth, the tripartite interaction pattern between physicians, nurses, and patients has been viewed as analogous to the patriarchal family. According to this myth, the subordinate nurse-mother is expected to remain close to the client-patient, to interact in a lengthy and loosely structured manner with the format ranging widely from casual conversation to assistance with intimate body functions, but to have no autonomy of action (Larsen & Baumgart, 1992). The powerful physician-father is expected to remain remote from the client-patient and nurse-mother, to interact in a brief and structured manner with the format confined to the disease/injury process; and to have the autonomy to deliver orders that determine all actions (Larsen & Baumgart). The patient-child is expected to abdicate all control and wait to be told what to do and what will be done (Kalisch & Kalisch, 1988; Larsen & Baumgart; Lovell, 1988; Passau-Buck, 1988; Stuart, 1994).

This myth has been the basis for the historical relationship of nurse deference and subordination to physicians. Evidence of this myth described in the

literature has included the following expectations of nurses: (a) "standing to attention" or giving up their place in the physicians presence, (b) fetching and carrying charts and diagnostic tools for physicians, (c) tidying up and changing the linen in physician call rooms, (d) laying out sterile trays and supplies prior to a physician's arrival, (e) phrasing recommendations in such a way as to not hurt physician pride, and (f) feeling responsible for keeping physicians happy and in a good mood.

Mythical images of nurses. The profession of nursing has throughout its history enjoyed a variety of images. Some of these images have been positive such as Florence Nightingale with her lamp, the World War II Nurse in military uniform, and the nurse wearing a starched white uniform and cap (Larsen & George, 1992; Muff, 1980). However, many images have been negative. These images have included the sex object, the old-maid, the battle-axe; the air-head, the comic figure, and the supporting actor who waits for physician orders to carry out the simplest of procedures that any competent nurse would have done before the doctor was contacted or arrived on the scene (Gordon, 1995; Muff). These latter group of images have been primarily created and perpetuated by media such as television, movies, cartoons, greeting cards, and fictional

literature (Larsen & George; Gordon, 1995). Most nurses have recognized the falseness of these popular images in today's nursing reality. Most physicians, administrators, politicians, and the public know, consciously at any rate, that nursing is more than these historical and popular media images portray. However, these mythical images of nursing have continued to influence the opinions of all parties as to acceptable attitudes and behavior from nurses and toward them (Boutilier, 1994; Larsen & George; Millward, 1995; Muff; Stuart, 1994).

Kalisch and Kalisch (1988) and the Alberta Association of Nurses (1990) researched the public opinion of nurses. Both of these authors indicated that the public perceived that nurses were humanistic, committed to their work, technically competent, usually submissive, sometimes intelligent, rarely autonomous or scholarly, playing a supportive role to physicians in patient care, and without independent influence on health care system issues.

An additional category of false images of nurses has been reserved for male nurses. These images have classified male nurses as being a medical school failure or want-to-be, a business school dropout, a mechanically or technically incompetent individual, or a homosexual (Brookfield et al., 1988; Muff, 1980). In other words, any

male who desires to become a nurse is either unmasculine or unable to get a "real job."

Nursing as a stopgap occupation for women. In this control myth, nursing is not seen as a profession to which female practitioners make a career commitment. Rather, it has been seen as work that is primarily undertaken to supplement the family income and before children arrive or after they have gone off to school. This control myth has been supported by the feminine gender role in which more value is placed on marriage and motherhood than on work (Kalisch & Kalisch, 1988). This myth is also an extension of the patriarchal idea that men's work is more important, more valuable, and must be well remunerated as men are supposed to be the primary financial providers for their families. Despite the fact that 70 percent of Canadian nurses work after marriage and during their child-rearing years (Baumgart & Wheeler, 1992), Kalisch & Kalisch; believe that a female nurse's career still takes a backseat to her husband's career and her families needs.

Nurse equals woman. In this control myth, it has been assumed that only women possess the attributes required to be successful as a nurse; and therefore, only women should be nurses (Watson, 1990). This control myth has sought to maintain the female gender domination and feminine identity

of nursing in an attempt to maintain the status quo of its oppression. Along with the control myth of nursing as a stop-gap occupation, this control myth has influenced the number and characteristics of individuals who have chosen to enter the profession of nursing, and their career aspirations and lifelong commitment to it (Donner, 1992; Kalisch & Kalisch, 1988; Larsen & George, 1992; Muff, 1980).

Nurses are also to blame with respect to perpetuation of this control myth. Male nurses have received much sexist treatment at the hands of their female colleagues. Student male nurses have faced discrimination in obtaining practical experience in obstetrics and gynecology and the provision of intimate care to female patients despite the fact that they have been examined on these issues to obtain degrees and licenses (Brookfield et al., 1988; Larsen & George, 1992). Practicing male nurses have often been taken advantage of by being thought of as more useful for their brawn and their ability to relieve female nurses from having to perform intimate care for male patients than for their brains or other abilities (Brookfield et al.). In addition, male nurses have faced similar difficulties experienced by women in traditionally dominated male

occupations where they are viewed and treated as "tokens" (Kanter, 1977; Larsen & George).

Health care equals medical cure. In this myth, medical care and health care are seen as interchangeable terms and that only medicine can meet all the needs of patients in the health care system (Evans et al., 1994; Passau-Buck, 1988). A serious outcome of this control myth is that physicians have been the health care experts that politicians and media reporters most often search out for facts and coverage of health care issues. Consequently, much of the work, problems, and research of other segments of the health care sector, including nurses, has gone under-reported and under-considered in decision-making (Gordon, 1995; Kutlenios & Bowman, 1994).

Table 4. Control myths of patriarchy in health care

1. Nurses as angels of mercy.
2. Physicians, nurses, and patients as a patriarchal family.
3. Mythical images of nurses.
4. Nursing as a stopgap occupation for women.
5. Nurse equals woman.
6. Health care equals medical cure.

Characteristics of Oppression

The literature reviewed described patriarchy as an oppressive force for women/nurses, and labeled these groups as oppressed based on the existence of three characteristics that typify oppression and maintain it (Duffy, 1995; Geary Dean, 1988; McNeil Whitehouse, 1991; Muff, 1988; Pheterson, 1990; Roberts, 1983; Spring & Stern, 1998; Stern, 1996; Watson, 1990). These characteristics are internalization, assimilation, and marginalization, and together they represent the third part of the conceptual model used in this study. The characteristics of oppression have been described as a result of the D/S hierarchies, and they influence the way in which women/nurses interact with members of their own and the dominant groups (Diaz & McMillin, 1991; Duffy; Geary Dean; Roberts).

It has been hypothesized that most, if not all, women/nurses have been impacted by internalization, but that not all of these individuals have undergone assimilation--why is unknown (Cox, 1991).

Internalization and Its Outcomes

The literature on internalization has suggested that women/nurses have incorporated four beliefs about themselves and their roles in society. These beliefs have been incorporated during primary and professional

socialization, and they have exerted a strong influence on the attitudes and behaviors of all women/nurses (Watson, 1990). These four beliefs are:

1. Oppressed group members and their roles are inferior and have less value (Muff, 1988; Roberts, 1983; Watson, 1990).

2. Dominant group members and their roles are superior and of more value (Roberts, 1983).

3. The inequalities and injustices that exist between members of oppressed and dominant groups are legitimate (Keen, 1991; Lovell, 1981; Roberts, 1983).

4. Oppressed group members should only want to adopt their prescribed gender and occupational roles despite the fact they have been labeled inferior and of less value (Baker Miller, 1986; Geary Dean, 1988; Keen, 1991; Muff, 1988; Pheterson, 1990).

Authors have described internalization as maintaining oppression through a mechanism known as a cycle of complementarity. In this cycle, the internalized beliefs have resulted in behaviors that either support the beliefs or fail to renounce them (Muff, 1988; Pheterson, 1990; Watson, 1990). The inability of nurses to resolve issues and the relative invisibility of nursing within health care has been contributed to internalization (Watson).

The literature contained the following examples of attitudes and behaviors that authors believed were evidence of internalization in society and the health care sector.

1. Women who make generalized devaluing remarks about their gender group (they can't be trusted, they gossip, they cannot make decisions, they need male influence to survive/thrive) (Freire, 1970; Keen, 1991 Wilson Schaef, 1992).

2. Women who make generalized over-valuing statements about men (they make better bosses, leaders, decision-makers, planners etc.) (Keen, 1991).

3. Women who prefer not to seek opinions, advise, information, and/or problem solving from other women, despite the fact that reputable female sources exist, because they believe these sources are inferior (Freire, 1970).

4. Nurses who make generalized, devaluing comments about the profession and its contribution to health care (Duffy, 1995; Geary Dean, 1988; Keen, 1991; McNeil Whitehouse, 1991; Muff, 1988).

5. Nurses who make devaluing comments about themselves as nurses and/or nurses who make themselves feel superior by making other nurses feel inferior (Keen, 1991; McNeil Whitehouse, 1991).

6. Nurses who deny or attempt to disguise that they are nurses (e.g. wear street clothes or refer to themselves by other titles) (Keen, 1991; McNeil Whitehouse, 1991; Muff, 1988; Roberts, 1983).

7. Nurses who make generalized, over-valuing comments about the profession of medicine and its contribution to health care (Keen, 1991).

8. Nurses who fail to pay the respect nursing colleagues have earned such as not using the title of Doctor (McNeil Whitehouse, 1991).

9. Nurses who prefer to seek opinions, advise, information, and/or problem solving from non-nurse sources, despite the fact that reputable nursing sources exist, because they believe that non-nursing sources have more credibility (Freire, 1970; Geary Dean, 1988; Keen, 1991; McNeil Whitehouse, 1991).

10. Nurses who are rewarded more for the completion of technical tasks than for meeting the psychosocial needs of patients (Keen, 1991).

11. Nurses who belittle the medical complaints of female patients by chalking them up to pre-menstrual syndrome or hypochondriacism (Keen, 1991).

Assimilation and Its Outcome

Authors have suggested that internalization creates feelings of inferiority and worthlessness amongst oppressed group members, and that these feelings result in emotional discomfort (Baker Miller, 1986; Cox, 1991; Wilson Schaef, 1992). To escape the discomfort, and to reduce the inequality they face in their personal and professional lives, it has been theorized that some women/nurses have rejected their prescribed gender and occupational roles and have adopted those roles prescribed for dominant group members. This process has been labeled assimilation, and it is believed that it represents an attempt to gain, by association, some of the opportunities and resources afforded to dominant group members (Ashley, 1980; Cox; Freire, 1970; Geary Dean, 1988; Keen, 1991; McNeil Whitehouse, 1991; Roberts, 1983; Stern, 1996; Wilson Schaef).

The literature contained the following examples of attitudes and behaviors that authors believed were evidence of assimilation by women/nurses in society and the health care sector.

1. Women who are unsupportive of another's efforts or even sabotage them in a phenomenon that has been coined the

Queen Bee Syndrome (Baker Miller, 1986; Wilson Schaef, 1992).

2. Successful women in male dominated occupations who are rewarded and treated as "tokens" whose success is used as false evidence that inequality does not exist and that women have all the same opportunities as men in society (Baker Miller, 1986; Roberts, 1983).

3. Women who prefer to socialize and work with men rather than women (Baker Miller, 1986; Roberts, 1983).

4. Nurses who work in areas more organized around the medical model of cure (intensive care areas and operating rooms) harbor animosity and see themselves as different and better than nurses that work in areas of nursing that are more organized around the nursing concept of care (palliative, medicine) (Keen, 1991).

5. Nurses who imitate physicians in dress, behavior, and/or language (Keen, 1991).

6. Nurses who prefer to be associated with professional groups other than nursing or with specialty nursing groups rather than groups representing the profession as a whole (Keen, 1991).

7. Nurses who believe that being asked to present to medical or other professional groups is more prestigious than presenting to a nursing group (Keen, 1991).

8. Nurses who believe that being published in medical journals or journals of other professional groups is more prestigious than being published in nursing journals (Keen, 1991).

9. Nurses who gain more satisfaction from doing delegated tasks then from nursing tasks (Keen, 1991).

10. Nurses who feel better about themselves when they are told "you are not like other nurses", "you should have gone to medical school," or "you would make a good physician" (Keen, 1991).

11. Nursing leaders who are more aligned with, and defend stronger, medicine and physicians than nurses and nursing (McCall, 1996; Roberts, 1983).

12. Nurses who oppress other individuals because they equate success with being able to "boss" others (Freire, 1970; McCall, 1996; Roberts, 1983).

It has been hypothesized that assimilation supports the fear of freedom that has been instilled in members of oppressed groups. Assimilated individuals fear emancipation because it would require they give up attitudes and behaviors that have brought them some degree of comfort, opportunity, and resources, particularly power, from being like the dominant group (Freire, 1970; Roberts, 1983). What assimilated individuals have failed to recognize; however,

is that the opportunity and resources allotted to dominant group members does not derive from superior academic, clinical, political, or administrative skills but from long-standing social, political, and economic privileges (Chinn & Wheeler, 1985; Thomas & Droppleman, 1997).

Marginalization and its Outcomes

Marginalization is believed to be an outcome of assimilation. Authors have defined marginalization as a situation in which assimilated individuals end up having no group affiliations. Members of their own group do not accept these individuals because they have rejected this group's norms. However, these individuals are also not accepted by members of the dominant groups because these individuals remain fundamentally different in some way (they are not men/physicians) (Baker Miller, 1986; Cox, 1991; Roberts, 1983). Authors have suggested that marginalization has two major categories of negative outcomes for women/nurses. The first category includes sanctions such as economic hardships, physical attacks, derogatory labels, social ostrication, and guilt inducement perpetuated by members of both the oppressed and dominant groups (Baker Miller; Wilson Schaef, 1992). The second category includes nursing leaders who have lost touch with the grassroots issues of nursing and who carry the biases

of the dominant group. These leaders have been referred to as Aunt Janes, and they are believed to negatively impact the profession of nursing. These leaders continue to act as the subject matter experts who provide advice and information, make recommendations for actions, and speak for other nurses despite the fact that they are no longer affiliated with these nurses (McCall, 1996; Roberts).

Emotional Responses to Oppression

The literature reviewed described five emotional responses displayed by women/nurses because of internalization. These responses included self-hatred, dependency, powerlessness, internal conflict, and anger. Together they represent the fourth phase of the conceptual model used in this study. It is assumed that these responses are heavily interrelated with many linkages that augment and sustain each other and many of which are unknown at this time.

Self-Hatred

Internalization is believed to result in women/nurses who have an inferiority complex, who distrust each other, and who dislike themselves as individuals and as members of a group that lacks opportunities and resources (Baker Miller, 1986; Cox, 1991; Duffy, 1995; Freire, 1970; Keen, 1991; McCall, 1996; McNeil Whitehouse, 1991; Muff, 1988;

Pheterson, 1990; Smith et al., 1996; Roberts, 1983; Watson, 1990; Wilson Schaef, 1992).

Authors have linked self-hatred to several enduring issues for the profession of nursing: (a) low individual and professional self-esteem and self-depreciation; (b) fragmentation, divisiveness, and a lack of internal unity within the profession; (c) a lack of supportive behaviors among nurses including mentoring, networking, and preceptorships; and (d) informal, day-to-day, supportive behaviors among individual nurses.

Dependency

Women/nurses are described in the literature as dependent on men/physicians. Women are depicted as dependent on men for approval and to maintain their self-esteem (Freire, 1970; Muff, 1988). The bulk of nurses are depicted as dependent on physicians for the patients to whom they deliver care (Aaronson, 1989; Boutilier, 1994; Stuart, 1994) and for that portion of their practice that involves implementing medical orders and carrying out medically delegated tasks (Larsen & Baumgart, 1992). Known as structural dependence, this latter state has been credited with contributing to nursing's limited autonomy over its practice. Nurses have been given large amounts of responsibility, but they have not been given the

corresponding amount of organizational and/or professional authority (Ashley, 1973; Cox, 1991; Donner, 1992; Larson & Baumgart, 1992; Larsen & George, 1992; Radsma, 1994; Roberts, 1983; Smith et al., 1996; Watson, 1990). Dependency is believed to contribute to the anger and internal conflict that nurses experience (Duldt, 1981; Duffy, 1995).

Powerlessness

Backer et al. (1994) described power as manifest by awareness, choices, freedom to act intentionally, and involvement in creating change. Authors believe that the subordinate positioning of women/nurses in society and the health care sector has resulted in a state where these individuals are afforded lesser amounts of power and are not prepared to understand, recognize, or maximize the potential for power that they do have (Ashley, 1973; Ashley, 1980; Baker Miller, 1986; Cox; 1991; Donner, 1992; Duffy, 1995; Keen, 1991; McCall, 1996; Smith et al., 1996). For nurses, this potential includes the education and skills nurses possess; the significant contributions nursing care makes to positive patient outcomes; and the sheer weight of nursing numbers in any given health institution or on a provincial, national, or global basis (Radsma, 1994; Watson, 1990; Wilson Schaef, 1992). Smith et

al., in discussing a 1992 survey conducted by Valentine, indicated that five out of six female nurses viewed power negatively and did not see powerfulness as a desirable quality for nurses. Smith et al. used this finding as evidence that women/nurses remain oppressed despite the fact that over 20 years has elapsed since the women's movement of the 1970s.

The skewed stance on power, and its place in the profession of nursing, has been linked to other issues existing within the profession. These issues have included passivity; invisibility; and silence in the face of changes/challenges that impact nursing practice, health policy, and patient care (Ashley, 1973; Ashley, 1980; Droppleman & Thomas, 1996; Duffy, 1995; Duldt, 1981; Freire, 1970; Norman, et al.; Smith, et al., 1996; Spring & Stern, 1998).

Internal Conflict

Internalization is believed to create internal conflict for women/nurses, because these individuals are aware that their prescripted, stereotypical gender and occupational roles have little in common with the actual roles that they have assumed in their private and occupational lives (Baker Miller, 1986; Cox, 1991; Donner, 1992; Duffy, 1995; Duldt, 1981; Kalisch & Kalisch, 1988;

Larsen & Baumgart, 1992; Larsen & George, 1992). For nurses there have been an incongruence between the popular, mythical image of nurses and the contributions they makes to health care and the reality. Today, nurses are highly educated and skilled professionals with a pivotal role in providing and coordinating care. They make independent life and death decisions in a workplace that is becoming increasingly technical and high-risk (Cox, 1991; Dodd & Gorham, 1994; Gordon, 1995; Larsen & George).

Anger

Anger is an ancient emotion in humans and is related to other emotions such as fear and anxiety (Baron, 1977; Buss, 1961; Spielberger et al., 1995). It is an emotion that is experienced throughout the life span, and it is a normal response to situations, attitudes, or behaviors that are unwanted and/or offend one's values, beliefs, or human rights (Smith, et al., 1996). Despite its normalcy and universality, anger has not been well understood in women. This is due to the fact that most studies of anger have not considered it a gender issue, have not included female subjects, or have designed tools to measure anger as it has been defined by the masculine gender role (Smith et al.; Campbell, 1993, Spielberger et al., 1995).

Women and men have been socialized to experience and express anger differently (Campbell, 1993, Droppleman & Thomas, 1996; Duldt, 1981; Powell, 1996; Smith t al., 1996; Wilson Schaef, 1992). For men, expression of anger has been characterized as socially acceptable because it is a part of the masculine gender role; therefore, its expression has been viewed as a positive force to be used to win and/or impose control over others (Campbell; Powell). Men have been socialized to deal with their anger by expressing it as it occurs and by directing it at the individual and/or situation that caused the anger (Campbell; Olson, 1994). For women, expression of anger has been characterized as socially unacceptable because it is not a part of the feminine gender role; therefore, its expression has been viewed as a negative force that signals a loss of self-control. Women have been socialized to believe that their anger is a destructive and frightening force which could reek total destruction and interfere with their role as women (Campbell; Kutlenios & Bowman, 1994; Muff, 1988; Powell; Wilson Schaef). In this way, patriarchy has prevented women from utilizing the power of their anger to make changes in their status quo of oppression (Campbell; Kutlenios & Bowman; Muff; Powell; Wilson Schaef). Women have been socialized to suppress their anger again and

again over time until "a straw breaks the camels back" and all this pent-up anger is released (Wilson Schaef). When this happens, many women have experienced guilt and embarrassment for behaving in a socially unacceptable manner (Campbell), and they have often been labeled irrational because the expressed anger was excessive and/or unconnected to the individual or situation that triggered its release (Wilson Schaef). Also, because overt expression of anger as it occurs and toward the individual or situation that caused it has been deemed unacceptable for women/nurses, these individuals have been robbed of the opportunity to use this anger to make positive changes in their lives and practice (Johnson & Arneson, 1991).

Anger in the nursing workplace has been documented in a number of empirical studies involving female and male nurses in a variety of settings (Droppleman, & Thomas, 1996; Duldt, 1981; Smith et al., 1996; Thomas & Droppleman, 1997). The two primary sources of anger identified in these studies were the stressful nature of nursing and the hostile nature of the work environment (Duldt, 1981; Smith et al.; Droppleman & Thomas). One aspect of this environment that was highlighted was the inequality that nurses faced in a system that was openly patriarchal and in which they were repeatedly demeaned, patronized, ignored,

undervalued, discredited, and used as scapegoats by physicians and by facility and nursing administration (Baker Miller, 1986; Smith et al.; Duldt; Droppleman & Thomas). Authors have linked anger with: (a) workplace stress, job dissatisfaction, frustration, and burnout; (b) absenteeism, turnover, and attrition; (c) feelings of powerlessness and loss of control; and (d) depression and fatigue (Droppleman & Thomas; Duldt; Roberts; Smith et al.;).

Submissive-Aggressive Syndrome

The fifth phase of the conceptual model used for this study has been labeled the submissive-aggressive syndrome. It has been suggested that the internal conflict and anger described above creates emotional tension that requires venting. However, it has also been suggested that the self-hatred, dependency, and powerlessness creates submissiveness which prevents members of oppressed groups from directly challenging the forces and/or individuals responsible for their oppression (Baker Miller, 1986; Freire, 1970; Keen, 1991; Napier Skillings, 1992; Roberts, 1983). Instead, it is theorized that members of oppressed groups vent emotional tension in other ways. Two such ways discussed in the literature are self-aggression and horizontal aggression. Together these types of aggression

represent the behavioral responses to oppression and form the last part of the conceptual model used in this study.

Behavioral Responses to Oppression

The literature described self-aggression as behaviors perpetrated by oppressed group members toward themselves. These behaviors have included alcohol, drug, and food abuse (Baker Miller, 1986; Campbell, 1993; Duldt, 1981; Wilson Schaef, 1992). The literature described horizontal aggression as behaviors perpetrated by oppressed group members toward individuals who are seen as safe targets. These individuals have included significant others and members of one's peer group (Baker Miller; Campbell; Droppleman & Thomas, 1996; Duffy, 1995; Duldt; Farrell, 1997; Freire, 1970; Geary Dean, 1988; Gropper, 1994; Hedin, 1986; McCall, 1996; McNeil Whitehouse, 1991; Muff, 1988; Napier Skillings, 1982; Radsma, 1994; Roberts, 1983; Thomas & Droppleman, 1997; Watson, 1990; Wilson Schaef, 1992).

Both self and horizontal aggression has been used as visible symptoms of oppression among women/nurses. However, for the purpose of this study, only horizontal aggression has been considered. Along with internalization, horizontal aggression has been described as a classic oppressed group behavior and its presence used as evidence in classifying women/nurses as oppressed groups (Duffy, 1995; McNeil

Whitehouse, 1991; Roberts, 1983; Stern, 1996). The presence of horizontal aggression has also been used by forces outside of nursing to label nurses as incapable of autonomous action and thus to justify continued paternalistic treatment (Roberts; Wilson Schaef, 1992).

Horizontal Aggression among Nurses

Horizontal aggression among nurses has been talked about within the profession for years, written about in a theoretical and anecdotal fashion since the 1980s, but studied empirically only since 1991. A search of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Health Star, the PsychLit, and the Sociofile databases yielded only three empirical studies involving horizontal aggression among nurses or any other group. In two of these studies, the focus was on oppression of nurses and horizontal aggression was mentioned only briefly as a byproduct of this oppression (McCall, 1996; Napier Skillings, 1991). In the other study, the focus was on all forms of workplace aggression for nurses with horizontal aggression emerging as one, albeit very important, form (Farrell, 1997). All three studies utilized qualitative methods (two exploratory and one grounded theory), and participant numbers ranged from five (McCall) to 29 (Farrell). Napier Skillings studied general duty and nurse

managers, McCall studied general duty and nurse clinicians, and Farrell studied general duty and university lecturers in a faculty of nursing. In only this latter study were the responses of general duty nurses isolated from the responses of other participants, and this endeavor suggested that the phenomenon of horizontal aggression was experienced differently by nurses at different levels of the nursing hierarchy. For this reason, it was decided to limit this study to a single group of nurses, specifically general duty/staff nurses as defined by the Manitoba Association of Registered Nurses (MARN). Only Farrell included male nurses in his study, but he did not illuminate any differences with respect to horizontal aggression based on gender. Therefore, it remains unknown if or how male nurses are impacted by nursing's oppression. All the studies identified their small sample sizes as limitations, and Napier Skillings also identified homogeneity of her sample as an issue. Only Napier Skillings and Farrell made recommendations for future study, and these included increasing the number of nurses sampled, focusing more specifically on the phenomenon of horizontal aggression, and testing the hypothesized link between oppression and horizontal aggression. These first two recommendations prompted this study.

The findings of McCall (1996) and Napier Skillings (1992) shared many similarities. Participants described themselves, and the profession of nursing as oppressed; believed that medicine and institutional administration (who were seen as aligned with medicine) were the oppressors; characterized these oppressors as limiting nursing autonomy; and indicated that oppression resulted in typical, negative behaviors among nurses including horizontal aggression. Farrell (1997) found that horizontal aggression was of great concern to both groups of nurses he studied; however, this form of aggression was identified as secondary to the aggression that general duty nurses received from patients. All three studies found that nurses who had experienced horizontal aggression found it painful, and that the occurrence of horizontal aggression was under-reported. Only Napier Skillings elicited information about targets. The participants in her study indicated that being newly graduated and/or being different in some aspect (gender, race, sexual orientation, and mode of practice) were reasons why some nurses became targets of horizontal aggression.

Summary

The literature reviewed described patriarchy as an oppressive force for women in society, and by extension,

for nurses in the health care system. Both these groups were described as oppressed. A comprehensive review of literature from a number of domains resulted in the design of the conceptual model used in the study. According to this model, patriarchy has resulted in D/S hierarchies based on gender and on gender and occupational roles that are maintained by control myths and fears. These hierarchies have resulted in men/medicine being labeled superior and women/nurses being labeled inferior. Consequently, women/nurses have been afforded less opportunity and resources than men/physicians. This inequality has resulted in the existence of three typical characteristics of oppressed groups--internalization, assimilation, and marginalization. The outcomes of internalization include five emotional responses. Anger and internal conflict have created emotional tension and self-hatred, powerlessness, and dependency have created submissiveness. This submissiveness has prevented women/nurses from directly challenging their oppressors and encouraged them to release emotional tension by behaving aggressively toward themselves or toward others who were seen as safe targets. When coworkers were chosen as the targets of this displaced aggression, the phenomenon has been called horizontal aggression. Horizontal aggression

has been considered a typical behavioral response to oppression, and its existence within nursing has been cited as evidence that nurses are an oppressed group.

Horizontal aggression has been talked and written about within nursing for over 30 years. However, empirical study has been limited to three qualitative studies with small numbers of participants. The findings of these studies indicated that horizontal aggression was a reality in the nursing workplace that had negative outcomes. The findings identified oppression as the cause and medicine and institutional administration as the oppressive forces. These studies indicated that horizontal aggression was a subject that warranted further study utilizing methods that would allow a narrow focus on horizontal aggression specifically and would incorporate larger numbers of subjects. These recommendations provided the stimulus for this study whose methods have been described in the following chapter.

CHAPTER THREE

METHOD

Research Design

The research questions of the study were answered by employing a non-experimental, retrospective, and descriptive research design.

Data Collection

Data was collected using a four-part, self-report survey designed for use in this study. This survey collected qualitative and quantitative data from nurses who were able to recall an incident in which another nurse treated them in a manner that matched the definition of horizontal aggression that was used in this study. These respondents were labeled as targets. The survey also collected quantitative, demographic data from nurses who were unable to recall any incident in their career in which another nurse treated them in a horizontally aggressive manner. These respondents were labeled as non-targets.

The first part of the survey was patterned after the Critical Incident Technique (CIT) developed by Flanagan (1954) and elicited descriptive data about an incident of horizontal aggression from targets. The CIT technique was chosen for this portion of the survey because it provided a flexible process for gathering information concerning

behavior in a defined situation (Flanagan; Fly, van Bark, Weinman, Strohm Kitchener, & Lang, 1997; Norman et al., 1992). The CIT has been used widely in the fields of psychology, sociology, management, education and training, social work, and in a variety of nursing studies. These have included (a) evaluating the performance of student and practicing nurses in different areas, (b) describing the behaviors that result in high and low quality nursing care, (c) illuminating the behaviors that result in medication errors, and (d) classifying the behaviors of different types of patients (Fivars & Gosnell, 1966; Flanagan; Norman et al.). The CIT has been used in one-on-one interviews, group interviews, and via survey with equal success (Flanagan). In this study, the CIT portion of the survey permitted data collection from a larger sample than previous studies, but it still allowed respondents to provide descriptive data on the phenomenon in their own words.

The second part of the survey asked targets to respond to additional questions about the incident they had described in Part one, about themselves, about their perpetrator, and about horizontal aggression within nursing. These questions were primarily quantitative in

nature; however, respondents were encouraged to provide qualitative comments where possible.

The third and fourth parts of the survey elicited demographic data. Part 3 elicited demographic data from targets about themselves and about their perpetrators. Part 4 elicited demographic data from non-targets about themselves.

Instrument Reliability and Validity

The following steps were taken in order to enhance the reliability and validity of the survey. First, in accordance with the recommendations provided by Flanagan (1954) and Fivars and Gosnell (1966), targets were instructed to focus on the most recent incident of horizontal aggression that matched the definition provided. It was hoped that this measure would prevent targets from describing the most dramatic incident that had ever happened to them, combining a number of incidents into one, and/or describing stereotypical events. Second, a panel of individuals with expertise in survey methods and horizontal aggression critiqued the survey. Their suggestions were incorporated into the final version of the survey. Lastly, the survey was pilot tested with a small sample (n=15), and revisions made as warranted.

Sample

Sampling Criteria

To be included in this study, respondents had to be general duty/staff registered nurses. Targets had to be able to provide a detailed description of an incident in which another general duty/staff registered nurse treated them in a horizontally aggressive manner.

Pilot Test

Respondents for the pilot test were conveniently sampled from nurses who were enrolled in the Baccalaureate Program for Nurses (BPRN) at the University of Manitoba. Written permission to recruit respondents was obtained from the Dean of the Faculty of Nursing, from the BPRN Program Coordinator, and from the professors of the two largest BPRN classes. As mandated by the Faculty of Nursing Ethical Review Committee, only students in the two largest classes were approached to safeguard the anonymity of respondents. Once permission was obtained, the researcher attended each of the two classes, explained the purpose of the study, distributed pilot survey packages to those nurses who met the sampling criteria, and requested those nurses who elected to participate to not repeat the same incident if they received a survey later by mail. These pilot survey package contained: (a) a covering letter, (b) the version

of the survey that had been approved by the panel of experts, (c) a questionnaire to elicit feedback with respect to the design and content of the survey, (d) a request form for those respondents who wished a summary report of the findings, and (e) an addressed and stamped envelope for respondents to return their survey anonymously to the researcher.

Forty pilot survey packages were distributed, and 37.5 percent (n=15) were returned. Of these 15 responses, 10 percent (n=4) were non-targets who completed only the fourth part of the survey, and 27.5 percent (n=11) were targets who completed the first three parts of the survey.

Pilot surveys were well completed and only minimal changes to the instrument were required prior to its use in the main survey. Based on this fact, the data from these 15 pilot respondents were included in the final data analysis.

Main Survey

There were 6927 nurses in Manitoba who identified themselves as general duty/staff nurses on their 1999 Manitoba Association of Registered Nurses (MARN) registration form (personal communication Marta Crawford, MARN Consultant, Nursing Practice, 08 April, 1999). From this population, MARN staff randomly chose 500 names and sent those nurses a survey package. This package contained:

(a) a covering letter (Appendix A), (b) the final version of the survey (Appendix B), (c) a request form for those respondents who wished a summary report of the findings (Appendix C), and (d) an addressed and stamped envelope for respondents to return their survey anonymously to the researcher. Two weeks after this initial mailing, MARN staff sent these same 500 nurses a reminder letter (Appendix D). The number 500 was chosen by the researcher based on a common response rate for self-report instruments of 30 percent which was expected to yield n=150 respondents. This number was considered sufficient to accomplish the purposes of this study, was in keeping with the literature on CIT sample sizes (Flanagan, 1954), and was expected to generate an amount of data feasible for the researcher to analyze. In reality, 33.6 percent (n=168) of surveys were returned. Of these, 11 were improperly completed and four were received after data analysis was complete. Therefore, the data contained in these 15 responses was not used.

Final Response Rate

The combined responses from the pilot test (n=15) and the main study (n=168) resulted in a final response rate of 36.6 percent (n=183). As mentioned above, 15 responses were unusable yielding n=168 responses that were analyzed. Of

these 168 responses, 69 percent (n=116) were non-targets and 31 percent (n=52) were targets. A number of possible scenarios may have prevented some of the nurses sampled from participating in the study and/or determined whether respondents choose to complete the entire survey or just the demographic sheet. These scenarios may have included some or all of the following.

1. Horizontal aggression is an emotive topic focussing on a negative aspect of nursing. Therefore, some nurses may have elected to not participate in the study or to not consider the existence of this workplace phenomenon.

2. This study was aimed at targets of horizontal aggression and some nurses may not have been comfortable admitting that they had been victims of this type of aggression.

3. Other workplace issues (pending labor disputes, reorganization, etc.) may have taken precedence over participating in this study and/or overshadowed the importance of studying horizontal aggression.

4. Respondents might not have been able to recall an incident in which they were the targets of horizontal aggression. As many authors have suggested, this form of aggression often goes unidentified because many nurses deny, minimize, rationalize, and/or tolerate this behavior

as "a part of the job" (Ashley, 1980; Duffy, 1995; Farrell, 1997; Keen, 1991; McCall, 1996; Muff, 1988; Napier Skillings, 1991; Roberts, 1983; Spring & Stern, 1998; Droppleman & Thomas, 1996).

5. Targets were required to complete three parts of the survey, one part that required them to write out an incident. These activities took 30 to 45 minutes. By contrast, non-targets completed only one part of the survey without a written component. This activity took only five minutes.

Data Analysis

Flanagan (1954, 1974) and Fly et. al. (1997) guided the analysis of data provided by respondents. This analysis included the following steps.

1. The data was sorted and grouped under major headings that were based on the research questions.
2. The data under each heading was sorted and grouped into distinct categories and subcategories that were created and defined.
3. The data contained in each category and subcategory was generally and specifically described, its frequency was detailed, and other descriptive statistics (measures of central tendency and variability) were expressed when appropriate.

Limitations Associated With Method Used

The method described above is believed to represent the best design for the purpose of this study and to answer the research questions. However, it must be acknowledged that this method does have some limitations. These include:

1. The design was non-experimental in nature and therefore generalization of the findings to a wider population is limited.

2. Only those nurses that identified themselves as being employed as a general duty/staff nurse on the 1998 MARN Registration Form were afforded the opportunity of being selected to participate in the study.

3. The study utilized a mail-out survey so the accuracy of data was limited by the ability of each respondent to understand the survey questions, to accurately recall the details of incidents that occurred in the past, and to express themselves in writing.

4. The survey requested respondents to write out an incident of behavior, a task estimated to take a minimum of 30 minutes, which may have reduced the response rate from targets.

Ethical Considerations

Prior to any action, ethical review was obtained from the University of Manitoba Faculty of Nursing Ethical

Review Committee (Appendix E), in accordance with their Ethics Review Form, and from MARN (Appendix F), in accordance with their policy statement *Access to Membership Names for Research Purposes*. Informed consent was accomplished by explaining the study in the covering letter (Appendix A) and providing a contact number (the thesis committee chair) for respondents who required additional information before deciding to participate. Respondents granted their consent by returning a completed survey and were informed of this aspect in the covering letter. The covering letter reminded respondents that their participation was purely voluntary. Respondents were able to easily avoid participating by not returning a survey. Coercion was not seen as an issue in this study because the researcher was not in a position of power vis-à-vis the respondents and had never been employed as a nurse in the province of Manitoba. Access to completed surveys, and electronic data compiled from these surveys, was limited to the researcher and her thesis committee. Confidentiality of respondents was maintained by assigning each survey a respondent number. No names were used or were accessible in any way by the researcher. The researcher had no access to the MARN data bank or to the final list of names produced after random selection from this list. Likewise, the

researcher was not provided with a class list or any other source of student identification from the BPRN courses that were accessed. Respondents were instructed not to put any identifying marks on their survey or return envelope. Those respondents who wanted a summary report of the study were asked to complete the request form provided with the survey and seal it in the small, addressed envelope provided for this purpose. Respondents were then offered two options: to return this envelope with their survey or to mail it separately. Regardless of delivery method, these envelopes were locked in a filing cabinet and not opened until the data analysis was complete and the summary had been written. For this reason, it is considered virtually impossible for the researcher to connect individual respondents with the data they provided. Respondents and the researcher never interacted in a face-to-face manner except for a very brief, one-way interaction with pilot test respondents during which these respondent did not identify themselves by name, location of work, or any other personal information. Completed surveys, along with electronic data produced from them, will be kept for seven years in a locked filing cabinet in the researchers home. After this period, documents and disks will be destroyed. No original data obtained from the surveys will be made

public. However, a summary of the findings of this study will be submitted to select nursing journals for publication. This fact was also detailed in the covering letter.

It is estimated that the respondents will benefit indirectly from the study based on the increased awareness of horizontal aggression and the stimulation of further research on this form of workplace aggression. The burden and risk to individual respondents was limited. By participating, respondents had to give up to a maximum of 45 minutes of their time to complete the survey, and it was possible that reflection on past aggressive incidents may have caused some discomfort. For this reason, the covering letter to the survey alerted respondents to this possibility and provided respondents with contact information of resources to assist them in this eventuality.

Summary

This study employed a non-experimental, retrospective, and descriptive research design that utilized a self-report survey whose design was guided by the CIT (Flanagan, 1954). Efforts were made to improve the reliability and validity of the survey by having it critiqued by a panel of experts and by subjecting it to a pilot test. Ethical approval for

the study was granted by both the University of Manitoba Faculty of Nursing and by the MARN. Every effort was made to treat respondents in an ethical manner. A random sampling method was used to access 500 nurses that met the sampling criteria. A response rate of 36.6 percent (n=183) was achieved and a pool of n=168 responses were analyzed. Of these 168 responses, 69 percent (n=116) were non-targets and 31 percent (n=52) were targets. The findings from the analysis process will be discussed in the next chapter.

CHAPTER FOUR

FINDINGS

The survey utilized in this study was designed to elicit qualitative and quantitative data that would answer the research questions. These questions have been used as the organizing framework for this chapter. It is important to note that target and non-targets provided their own data, but data about perpetrators was provided by targets alone.

The Existence and Frequency Of Horizontal Aggression

Existence

Nurses in Manitoba are experiencing incidents of horizontal aggression. This statement was supported by the fact that 31.0 percent (n=52) of the total number of survey respondents were able to document a recent incident of this type of behavior.

Frequency

The data elicited with respect to the frequency of horizontally aggressive behaviors was grouped into five categories. The first, second, and third categories described the frequency of horizontal aggression on the unit and in the facility where the incident took place and in the province of Manitoba. The fourth category described

the frequency that targets experienced horizontal aggression during their careers. All categories were measured using a 4-point Likert-type scale that included the responses rarely, sometimes, often, and very often. The fifth category described the frequency that perpetrators had engaged in horizontally aggressive behaviors in the past.

Unit, facility, provincial frequency. The majority of targets believed that horizontal aggression among nurses (a) often occurred on the unit where the incident they described took place (40.3 percent, n=21), (b) sometimes occurred in the facility where the incident they described took place (42.3 percent, n=22), and (c) often occurred throughout the province of Manitoba (48.0 percent; n=25).

> This sort of thing happens so often where I work that I don't even care anymore (S027).

> I worked in Louisiana for five years and was rarely the target of horizontal aggression. I experienced it less in the five years there than in the seven months I have worked here in Manitoba (S027).

Target frequency. The majority of targets (57.7 percent; n=30) indicated that they had rarely been a target of horizontally aggressive behavior throughout their careers.

Perpetrator frequency. Targets were asked two separate questions with respect to the frequency that perpetrators

had engaged in horizontally aggressive behavior in the past. When asked if their perpetrator had ever treated them in a horizontally aggressive manner before, 5.8 percent (n=3) strongly agreed, 36.5 percent (n=19) agreed, 11.5 (n=6) percent expressed no opinion either way, 25 percent (n=13) disagreed, and 21.2 percent (n=11) strongly disagreed. When asked if their perpetrator had a history of treating other nurses in an aggressive manner, 40.4 percent (n=21) strongly agreed, 36.5 percent (n=19) agreed, 21.1 percent (n=11) expressed no opinion either way, and 1.9 percent (n=1) strongly disagreed.

Individual Demographic Factors

Individual demographic factors were grouped into 11 categories as described in the following paragraphs and detailed in Appendix G. Each category had four subcategories: (a) demographics that described targets; (b) demographics that described perpetrators; (c) demographics that described non-targets, and (d) demographics that described similarities and differences among targets and perpetrators. Except in the case of gender and ethnic background, which are unchanging, the remainder of factors described targets and perpetrators at the time that the horizontally aggressive incident took place. In the case of non-targets, all factors described

these individuals at the time they completed the study survey.

Gender

The majority of targets (98.1 percent; n=51), perpetrators (96.2 percent; n=50), and non-targets (96.6 percent; n=112) were female.

Ethnic Background

The ethnic background of targets included Caucasian (90.3 percent; n=47), which was the majority; Metis (3.8 percent; n=2); Asian (3.8 percent; n=2); and other (1.9 percent (n=1). The ethnic background of perpetrators included Caucasian (84.6 percent; n=44), which was the majority; Native (1.9 percent; n=1); Asian (3.8 percent; n=2); other (7.7; n=4); and unsure (1.9 percent; n=1). The ethnic background of non-targets included Caucasian (94.0 percent; n=109), which was the majority; Metis (1.7 percent; n=2); Asian (1.7 percent; n=2); and other (2.6 percent; n=3).

Age

Targets ranged in age from 20 to 59 years, but the majority (38.5 percent; n=20) were between 30 and 39 years. Perpetrators ranged in age from 26 to 69 years, but the majority (46.2 percent; n=24) were also between 30 and 39 years. Non-targets ranged in age from 20 to 69 years, but

the majority (43.1 percent; n=50) were between 40 and 49 years.

Nursing Education

The highest level of nursing education held by the majority of targets (84.6 percent; n=44), perpetrators (82.6 percent; n=43), and non-targets (85.3 percent; n=99) was a nursing diploma. A baccalaureate in nursing or science in nursing (BN/BScN) was held by 13.5 percent (n=7) of targets, 9.6 percent (n=5) of perpetrators, and 12.9 percent (n=15) of non-targets. A masters in nursing was held by 1.7 percent (n=2) of non-targets.

Nurse Seniority

The length of time that targets had been registered as nurses ranged from less than one year to greater than 31 years, but the majority (28.8 percent; n=15) had been nurses for six to 10 years. The nurse seniority of perpetrators ranged from less than one year to greater than 31 years, but the majority (23.1 percent; n=12) had also been nurses for six to 10 years. The nurse seniority of non-targets ranged from less than one year to greater than 31 years, but the majority (22.4 percent; n=26) had been a nurses for 31 years or more.

Employment Status

Individuals were employed in a variety of positions working a variety of hours as listed in Appendix G. The majority of targets (55.8 percent; n=29) worked in a permanent position with part time hours. The majority of perpetrators (50.0 percent; n=26) worked in a permanent positions with full time hours. The majority of non-targets (63.8 percent; n=74) were working in a permanent position with part time hours.

Position Seniority

The length of time that targets had been employed in their position ranged from less than 14 days to more than 91 days, but the majority (82.6 percent; n=43) had been employed for 91 days or more. The position seniority of perpetrators ranged from 31 days to more than 91 days, but the majority (76.9 percent; n=40) had also been employed for 91 days or more. The position seniority of non-targets ranged from 31 days to more than 91 days, but the majority (98.3 percent; n=114) had also been employed for more than 91 days.

Shiftwork

A combination of the three different eight hour shifts (days, evenings, nights) was worked by 53.8 percent (n=28) of targets, 48.1 percent (n=25) of perpetrators, and 60.3

percent (n=70) of non-targets. A combination of the two different 12 hour shifts (days and nights) was worked by 23.1 percent (n=12) of targets, 25.0 percent (n=13) of perpetrators, and 31.0 percent (n=36) of non-targets. Some combination of both eight hour and 12 hour shifts was worked by only 1.9 percent (n=1) of targets and only 3.8 percent (n=2) of perpetrators.

Nursing Area of Practice

Targets and perpetrators worked in 14 different areas of nursing practice while non-targets worked in 18. These areas are listed in Appendix G. The majority of targets (19.2 percent; n=10) and perpetrators (19.2 percent; n=10) worked in a critical care area. The majority of non-targets (23.3 percent; n=27) worked in geriatrics.

Geographical Location of Practice

Targets and perpetrators worked in five geographical areas of the province while non-targets worked in 11. These areas are listed in Appendix G and displayed on the map in Appendix H. The majority of targets (82.6 percent; n=43), perpetrators (82.6 percent; n=43), and non-targets (56.8 percent; n=66) worked in the Winnipeg region.

Similarities and Differences Between Individual Targets and their Perpetrators

In 94.2 percent (n=49) of incidents, targets and perpetrators were the same gender.

In 78.8 percent (n=41) of incidents, targets and perpetrators were from the same ethnic background. However, in 19.2 percent (n=10) of incidents they were from different ethnic backgrounds.

In 25.0 percent (n=13) of incidents, targets and perpetrators were within the same age group. However, in 46.2 percent (n=24) of the incidents, targets were younger than their perpetrator and in 26.9 percent (n=14) of incidents targets were older.

In 75.0 percent (n=39) of incidents, the highest level of nursing education held by targets and perpetrators was the same. However, in 7.7 percent (n=4) of incidents, targets had less education than their perpetrator and in 9.6 percent (n=5) targets had more.

In 17.3 percent (n=9) of incidents, targets and perpetrator had the same amount of nursing seniority. However, in 34.6 percent (n=18) of incidents, targets had less seniority than their perpetrator and in 25.0 percent (n=13) targets had more.

In 42.3 percent (n=22) of incidents, targets and perpetrators had the same employment status. However, in 34.6 percent (n=18) of incidents, targets worked less hours than their perpetrator, and in 11.5 percent (n=6) targets worked more hours.

In 67.3 percent (n=35) of incidents, targets and perpetrators had the same amount of employment seniority. However, in 11.5 percent (n=6) of incidents, targets had less position seniority than their perpetrator and in 3.8 percent (n=2) of incidents targets had more.

In 90.3 percent (n=47) of incidents, targets and perpetrators worked in the same area of nursing, and in 100 percent (n=52) of incidents targets and their perpetrators worked in the same geographical area of the province.

Incident Demographic Factors

Incident demographic factors, or those factors that described incidents of horizontal aggression, were grouped into eight categories as described in the following paragraphs.

The Duration of Aggression

The length of time during which perpetrators behaved aggressively toward targets was deemed to be either short, confined to one interaction; medium, took place during more than one interaction but contained to one shift; and long,

took place during more than one interaction and for more than one shift. The majority of incidents (55.8 percent; n=29) were of short duration, while 25.0 percent (n=13) of incidents were of medium duration, and 19.2 percent (n=10) were of long duration.

The Location of Incidents

Horizontally aggressive incidents took place either in private or public locations. Private locations included those sites where third party bystanders could not see or overhear the incident as it occurred. Public locations included those sites where third party bystanders (other nurses, other health care staff, patients, and/or visitors) were present and were able to see and/or overhear the incident as it occurred. Public locations included the unit desk, hallway areas, patient care areas, and in one case at a private function. The majority of incidents 78.8 percent (n=41) took place in public while the remaining 21.2 percent (n=11) of incidents took place in private.

The type of Interaction

Interactions between targets and their perpetrators occurred in three different ways. The majority (80.8 percent; n=42) of incidents took place while the target and perpetrator where in the same vicinity and in direct contact with each other. In 19.2 percent (n=10) of

incidents, the horizontally aggressive behavior took place in the presence of third party individuals while the target was absent. In 9.6 percent (n=5) of incidents, the horizontally aggressive behavior took place over the phone.

Rate of Occurrence

Targets indicated that the incident they described occurred from less than seven days to more than 61 days prior to completing the survey. The majority of incidents (61.5 percent; n=32) were in this latter group.

The shift of Occurrence

The majority of incidents described by targets took place on a day shift (57.7 percent; n=30). In 32.7 percent (n=17) of incidents, it was an eight hour day. In 25.0 percent (n=13) of incidents, it was a 12 hour day. The remaining incidents took place during an eight hour evening shift (19.2 percent; n=10) or during a night shift (15.3 percent; n=8). In this latter group, four incidents took place during an eight hour night and four during a 12 hour night.

Target and Perpetrator Work History

Responses with respect to the frequency that targets and perpetrators had worked together prior to the incident targets described was rated on a 5-point Likert-type scale that included never, rarely, sometimes, often, and very

often. The majority of targets (28.8 percent; n=15) indicated that they and their perpetrators had often worked together.

Being a Float Nurse

In only 17.3 percent (n=9) of incidents, had targets been floated to the unit where the horizontally aggressive incident took place, and in only 5.8 percent (n=3) of incidents had perpetrators been floated.

Horizontally Aggressive Behaviors

Analysis of the qualitative data provided by targets yielded 141 horizontally aggressive actions that had occurred in the course of 52 incidents. These actions were grouped into 19 subcategories, each representing a distinct behavior. Each subcategory was labeled and defined, and then these 19 subcategories were grouped into five categories, or types, of aggression utilizing Buss's (1961) typology as explained in Chapter 1. These sorting activities have been summarized in Tables 5 (p. 109) and 6 (p. 116) and will be described in the following paragraphs.

Physical Aggression

Of the 19 subcategories of behaviors described by targets, five were physically aggressive. Four of these behaviors were active and direct forms of aggression (blocking, physically attacking, physically dismissing, and

throwing objects), while the remaining behavior (not providing patient coverage) was passive and indirect.

Physically dismissing. In this subcategory, the perpetrator removed herself from the target's vicinity by walking away or by hanging up the phone. The perpetrator's motivation for this behavior was to stop or prevent targets from speaking, thus robbing them of the opportunity to explain or defend themselves. This behavior occurred in 17.3 percent (n=9) of incidents and was the most frequent physically aggressive behavior reported by targets.

> She refused to continue the report and abruptly hung up (P055)
>
> I was explaining my rationale and she just stomped off (P003).
>
> …she burst into the [patient's] room, lectured me…she then left. I wasn't even given the opportunity to explain…I didn't even know who the person was that burst in (P055).

Throwing objects. In this subcategory, the perpetrator displayed her aggression by slamming doors, slamming down a phone receiver, or by throwing objects about without making direct contact with the target. This behavior occurred in 11.5 percent (n=6) of incidents.

> When I returned to my [patient's] bedside, she yelled at me from her bedside and slammed supplies around (P002).
>
> …she was throwing pens, charts, on her table (S093).

> She said I needed to grow up and walked out of the office slamming the door behind her (S120).
>
> She then comes in to the medication room, slams the door loud, and barges with more profanity (S122).

Blocking. In this subcategory, the perpetrator used her body or other objects to block the target's pathway and/or exit route. This behavior occurred in 3.8 percent (n=2) of incidents.

> …she cornered me in a conference room, shut the door, and stood in front of it thus blocking my only exit from the room (P048).

Physically attacking. In this subcategory, the perpetrator inflicted physical harm on the target by hitting, slapping, punching, kicking, biting or otherwise making physical contact with the target directly or with an inanimate object. This behavior occurred in 3.8 percent (n=2) of incidents.

> …she ran at me from the head of the patient's bed and slugged me in the stomach (S144).

Not providing patient coverage. In this subcategory, the perpetrator did not complete a work-related task for the target in her absence from the workplace or when she was occupied with another work-related task. This behavior occurred in only 1.9 percent (n=1) of incidents.

> I was monitoring a patient with chest pain. I heard my name being called out loud from the nurses' station. I looked out the door to say that I was busy but before I could speak, I was told rudely to come and look

> after this patient he was calling for a nurse. I went and checked on the patient who was right across from the nurses' station. Later [I asked her] why she couldn't attend to the patient's need who was right across [from] the desk… she said 'why the hell should I look after your patient?' (S122).

Table 5. Physically aggressive behaviors

	f	%
Active Direct		
Physically dismissing	9	17.3
Throwing objects	6	11.5
Blocking	2	3.8
Physically attacking	2	3.8
Passive Indirect		
Not providing patient coverage	1	1.9

f = frequency of incidents % = percentage of incidents

Verbal/Nonverbal Aggression

Of the 19 subcategories of behaviors described by targets, 14 were verbally aggressive which included some nonverbal subtypes. Ten of the 14 verbally aggressive behaviors were active and direct forms of aggression (being rude, condescending, cursing, insulting, intimidating, non-constructive criticism, sabotaging, scape-goating, uttering threats, and verbally dismissing). Two each were active and indirect (back-biting/gossiping and nit picking) and passive and direct forms (refusing to help and the silent treatment).

Being rude. In this subcategory, the perpetrator directed hostile verbal and/or non-verbal communications at

the target. These communications included rude remarks, yelling, using an inappropriate tone of voice, and displaying hostile body language and/or facial expressions.

> It wasn't what she said, but rather it was the tone that she said it in and the look of annoyance on her face (S026).

> She spoke quickly and harshly. Basically, body language, tone of voice, and wording were inappropriate and unprofessional (S057).

This behavior occurred in 59.6 percent (n=31) of incidents and was the most frequent verbally aggressive behavior reported by targets.

> She was so loud and rude with the lecture that followed that the surgeon stopped the surgery to see what was going on (S027)

> He would not let me speak and was very rude. He even swore at me (S123).

> …her tone was badgering and confrontational with the intent to force me to change my priority (S160).

Non-constructive criticism. In this subcategory, the perpetrator criticized, without cause and/or in a hurtful way, the target's personal life, professional ability (knowledge, skills, or the way the target did her job), and/or workload. Workload issues included the number and/or acuity of patients cared for; the number of hours, shifts, weekends, holidays etc. worked; and/or the number of extra tasks performed. This behavior occurred in 28.8 percent (n=15) of incidents.

> During this period [6 days of orientation], she criticized my work or the way I did procedures were not good enough. Even when I followed the procedure manuals, it was still not good enough. Any small/insignificant happening she would blow it out of proportion and make something critical out of it (S159).

> I was told that I should not do anything 'extra' for patients because only the minimum care is necessary and doing more makes other nurses look bad (S079).

Condescending. In this subcategory, the perpetrator treated the target in a condescending, sarcastic and/or belittling manner. This behavior occurred in 17.3 percent (n=9) of incidents.

> The nurse in question asked me out loud in a sarcastic manner if I thought I was the only one who could look after that patient (S053).

> …she was verbally rude and condescending to me at the nurses' desk in front of everyone. She gave me a five-minute lecture on what they do here on this ward (S115).

Insulting. In this subcategory, the perpetrator made an insulting remark about the target's professional abilities (knowledge, skills, or the way the target did her job) and/or personal characteristics. These remarks were made in the target's presence and often in the presence of others. This behavior occurred in 13.5 percent (n=7) of incidents.

> The night nurse just screamed at me in front of the other 8-9 nurses how stupid I was…(S076).

Scape-goating. In this subcategory, the perpetrator blamed the target for a situation that was not of the target's making or was not within the target's span of control. This behavior occurred in 11.5 percent (n=6) of incidents.

> I had just come on shift and assessed the patient. I decided that an immediate transfer was necessary. I personally took the patient to the labor floor where the other nurse started yelling in front of other staff and within the patient's hearing that if she didn't find the fetal heart 'heads were going to roll' and [mine] would be one of them (S052).

Sabotage. In this subcategory, the perpetrator sought to damage the target's reputation and/or to prevent the target from completing a work-related task. Specific behaviors included in this category were purposely doing a poor job, doing the wrong task, not sharing information, spreading false information. This behavior occurred in 7.7 percent (n=4) of incidents.

> When I confronted my co-worker about violating my confidence she said she knew I did not want the note shown to our boss but she did it anyway (S056).

Intimidating. In this subcategory, the perpetrator purposely used her reputation to negatively influence the target's action or inaction. This behavior occurred in 7.7 percent (n=4) of incidents.

> You do not like to speak to her until spoken to. I would never consider asking her a question. I would rather call another ward (P076).

Verbal/nonverbal dismissal. In this subcategory, the perpetrator indicated that the target's physical presence and/or a verbal interaction was either not wanted or was not important. This behavior occurred in 7.7 percent (n=4) of incidents.

> …as charge nurse I needed to be kept informed of the patient's condition. Each time I entered the cubicle I was ignored. If I asked a question, it was ignored. At one point when I approached her because her patient was deteriorating and I was calling the house physician she raised her hand and turned her head away indicating she would not listen and that I should not speak. I sought the information I needed without her assistance. (P027).

Cursing. In this subcategory, the perpetrator addressed the target using language that was considered socially taboo. This behavior occurred in 5.8 percent (n=3) of incidents.

> …who the F--- do you think you are? (S122).
>
> …what the hell is your problem? (P055).
>
> …your being very bitchy…I have nothing to say to the bitch (S055).

Uttering threats. In this subcategory, the perpetrator threatened to behave verbally or physically aggressive toward the target at some time in the future. This behavior occurred in 5.8 percent (n=3) of incidents. In one such incident, the perpetrator threatened to spread malicious rumors about the target (P001). In another, the perpetrator

suggested that the target leave the workplace or she might "get sick" (S159).

Back-biting/Gossiping. In this subcategory, the perpetrator made critical and/or derogatory remarks about the target's professional ability (knowledge, skills, or the way the target did her job) or personality to others when the target was not present to defend herself. This behavior included gossiping or creating and/or spreading false and/or malicious information about the target. This behavior occurred in 15.3 percent (n=8) of incidents.

> name calling and putting me down behind my back (S081)
>
> bad mouthing me to the other nurses (S158).
>
> Other nurses in her department informed me that she was verbalizing to all staff that I was numerous things not so nice (P055).

Nit-picking. In this subcategory, the perpetrator, without reasonable cause and/or authority, reviewed the target's work looking for errors and/or omissions. This behavior occurred in 1.9 percent (n=1) of incidents.

Refusing to help. In this subcategory, the perpetrator verbally and/or nonverbally refused to complete or assist the target to complete a work-related task when the target had asked for this help. This behavior occurred in 7.7 percent (n=4) of incidents.

> …the nurse from another ward refused to do something for me which on that ward they are to assist us with [release blood from the blood bank]… She refused to even acknowledge that I was standing there. I politely asked her to do this task for me and again she refused and said they don't do this for us until after 1530 hours. She was rude and abrupt (S091).

> I wasn't very familiar with this type of pump, so I called the patient's ward and spoke to her nurse. I explained the situation to the nurse and asked that she come and trouble-shoot, as I felt so unfamiliar with the equipment. She refused, said she was too busy, etc. and hung up on me (P009).

Silent treatment. In this subcategory, the perpetrator refused to speak to or with the target socially or about work-related matters. This behavior occurred in 7.7 percent (n=4) of incidents.

> After this, she didn't really talk to me for a few weeks (P003).

> I came into the office where the night nurse was sitting and greeted her with 'good morning - how is it going with you?' pause - no comment just a scowl (S076)

> Two part time positions were posted for the OR. I was a successful applicant. She was not a successful applicant. When working together she was very cool. For several weeks I felt like I had 'daggers in my back' (S081).

> She would not say hello in the morning, would put on a walk-man at her desk and not answer if I tried to say something to her (S118).

Table 6. Verbally aggressive behaviors

	f	%
Active Direct		
Being rude	31	59.6
Non-constructive criticism	15	28.8
Condescending	9	17.3
Insulting	7	13.5
Scape-goating	6	11.5
Sabotaging	4	7.7
Intimidating	4	7.7
Verbally dismissing	4	7.7
Cursing	3	5.8
Uttering threats	3	5.8
Active Indirect		
Back-biting/Gossiping	8	15.3
Nit-picking	1	1.9
Passive Direct		
Refusing to help	4	7.7
Silent treatment	4	7.7

f = frequency of incidents % = percentage of incidents

Antecedent Factors

Analysis of the qualitative data provided by targets yielded 24 factors that targets believed were antecedent factors to the horizontally aggressive incidents they had experienced. These factors have been grouped into two categories and five subcategories as described in the following paragraphs and displayed in Table 7 (p. 123). There were 25.0 percent (n=13) of targets who were unable to identify any factors that they believed led up to the horizontal aggressive incident they had experienced.

> I'm not sure why this incident occurred. I have not done anything to this other nurse (P052).

> I really don't know why the incident occurred or what led up to it. The nurse seemed to become very angry without any warning (S033).

However, six of these 13 targets, did go on to suggest similar factors as those identified by the other targets.

> Perhaps the nurse was stressed or over-extended. However, so was I, and I found the strength to be polite, professional, and honest (P009).

> I realize that we are all busy and tired but that didn't excuse her behavior (S053).

Environmental Issues

Environmental issues existing within the workplace were identified by 50 percent (n=26) of targets as being an antecedent factor to the horizontally aggressive behavior that they experienced. Targets identified 11 factors that have been grouped into two subcategories: excessive workloads and rivalries.

Excessive workloads. Based on the descriptions provided by targets, a nurse, a shift, and/or a unit were said to be experiencing an excessive workload when one or more of the following situations occurred.

1. When one or more patients on the unit had an acuity level that was higher than normal for that unit

2. When an insufficient numbers of nurses were working to meet the care needs of the number of patients on the unit.

3. When an insufficient number of nurses were working with the experience required by the patients admitted to the unit. Experience included possession of specialized knowledge and skills and familiarity with the unit, its routines, and types of patients. This familiarity was gained through experience and by working on the unit for a significant period. When an insufficient number of experienced nurses were available to work, they were most often replaced by inexperienced nurses (newly graduated, new to the unit, and/or float nurses). This created a situation in which the ratio of experienced to inexperienced nurses became skewed creating an imbalance of workload between these two groups of nurses. The experienced nurses had to constantly care for the greatest number and acuity of patients, and had to shoulder additional responsibilities each shift. These responsibilities included being in charge; orientating, supporting, and teaching the inexperienced nurses; and being the subject-matter experts who were expected to be available to answer questions and solve problems for other nurses and for physicians, patients, and families.

Targets referred to situations when the number and/or experience level of nurses working was insufficient as "being short-staffed". Short staffing was described as an

acute problem in two incidents but as a chronic problem in 18. Targets made a direct link between chronic short-staffing and high rates of nursing turnover.

> Our ward has recently experienced a large staff turnover, making it more stressful for the senior workers who find themselves with more responsibility placed on their shoulders (S026).

Excessive workloads were identified by 38.5 percent (n=20) of targets who believed that this workload resulted in heightened emotional tension for their perpetrators and led to their perpetrators treating them in an aggressive manner. The emotions produced included (a) frustration and/or guilt because the perpetrator believed she could not deliver the quality or quantity of nursing care in accordance with the standards of the profession and/or her own individual standards (n=7); (b) emotional and physical fatigue from the excessive and unbalanced workload or from having to work additional hours/shifts (n=7); (c) increased stress (n=4); (d) burnout (n=3); and (e) time pressures of having too many tasks to do in too little time (n=2); and (f) anger (n=1).

Rivalries. Inter- or intra-unit rivalries were believed to be a contributing factor in the horizontally aggressive behavior experienced by 13.5 percent (n=7) of targets. Four of these incidents involved inter-unit

rivalry that occurred between different units within the facility. These rivalries were of a long-standing duration and had become part of the culture of these units.

> She [the perpetrator] was obviously not pleased that I had questioned her decision…staff nurses are not supposed to question an emergency nurse's decision.(P055).

> A factor that led up to it [the incident] was the longstanding rivalry between the two units [postpartum and labor and delivery] (S052).

Three of these incidents involved intra-unit rivalry that occurred among the nurses working on the same unit.

> Competition with peers is prevalent in this unit as is intolerance of different ways of doing things. It is a small unit and everyone looks over the shoulder of others (S115).

Perpetrator Issues

In the opinion of 73.1 percent (n=38) of targets, the horizontally aggressive behavior they experienced from their perpetrators was due, in whole or in part, to issues that were confined to their perpetrator herself. Targets reported over 15 separate factors which were grouped into three subcategories: perpetrators with a high level of personal stress, perpetrators with a negative reputation, and perpetrators trying to make themselves look good by making their targets look bad.

Personal stress. High levels of personal perpetrator stress was identified as an antecedent factor by 26.9

percent (n=14) of targets. Four factors were believed to have resulted in these high levels of stress:

(a) Perpetrators with problems in their personal life (marital, childcare, financial etc.) (n=9);

(b) perpetrators who were insecure with their abilities to perform as nurses (n=5); (c) perpetrators who were fatigued from working night shifts (n=3); and (d) perpetrators who had recently been the target of aggressive behaviors from other individuals (n=3).

A negative reputation. A perpetrator's negative reputation was identified as an antecedent factor by 40.3 percent (n=21) of targets.

> She is just a miserable person who needed to take her frustrations out on people around her (S118).

These targets identified 10 factors that contributed to a perpetrators negative reputation. These factors included: (a) treating other individuals (staff, patients, and families) aggressively (n=14), (b) being moody (n=3), (c) being impatient (n=2), (d) being inflexible (n=1), (e) being defensive (n=1), (f) being unable to admit when they had made a mistake (n=1), (g) being a chronic complainer (n=1), and (h) over-reacting to situations (n=1). In addition, n=14 of targets reported that their perpetrator had a history of being controlling and power

hungry. In this latter group, four of the incidents involved perpetrators who had been assigned to the charge nurse position for a shift and had, in their target's opinion, abused the limited power of this position.

> When she is in charge, she does have a power issue where she has to be in control. She thought I had usurped her authority. (P001).

The second and more common type of power and control issue occurred when the perpetrator was not functioning in the charge position. In these 10 incidents, the perpetrators behaved as if they had the authority to control the work of others and/or to monitor the quality of this work when in fact they did not. In four of the 10 incidents, targets described their perpetrators as "super nurses" who bolstered their own egos by trying to prove to others that they were indispensable. Targets described characteristics of the "super nurse" as being impatient with and refusing to assist other nurses that they deemed to be inferior to themselves (those possessing less experience or expertise for example), being a perfectionist with unrealistic expectations of others, being excessively bossy, and believing they knew more than anyone else.

<u>If You Look Bad, I Look Better</u>. This final subcategory of perpetrator issues was mentioned by 19.2 percent (n=10) of targets who believed that their perpetrators' aggressive

behavior was the result of the perpetrator trying to improve their own reputation at the target's expense. In seven of these 10 incidents, targets believed that their perpetrators were motivated by jealousy because the target had more experience or expertise on the unit or in the area of nursing (n=3), worked more hours (n=3), had successfully gained a position that the perpetrator had also wanted (n=3), had more education (n=2), or enjoyed a good reputation (n=1).

Table 7. Antecedent factors

	f	%
Perpetrator Issues	38	73.1
Negative reputation	21	40.3
Personal stressors	14	26.9
If you look bad, I look better	4	19.2
Environmental Issues	26	50
Workload and its outcomes	20	38.5
Rivalries	7	13.5

f = frequency of incidents % = percentage of incidents

Reasons Targets Were Chosen

Analysis of the qualitative data yielded 15 reasons that targets believed they had become targets of their perpetrators aggression. These reasons were grouped into five categories as described in the following paragraphs and displayed in Table 8 (p. 127). There were 13.5 percent (n=7) of targets who were unable to identify any reason why

they had been chosen as a target of their perpetrator's horizontal aggression. However, three of these seven targets, did go on to suggest similar reasons as those identified by the other targets.

Being Different

There were 40.3 percent (n=21) of targets who believed that they had become targets of their perpetrators' horizontally aggressive behaviors because they were different from their perpetrators in some way. These differences included (a) having a different personal and/or professional belief system (opposing viewpoints on minimum standards of care, approach to practice, method of delivering interventions, values, etc.) (n=5); (b) being younger in age (n=4); (c) having more position seniority (n=3); (d) having a different ethnic background (n=2); (e) having less experience as a nurse (n=1); (f) having more experience as a nurse (n=1); and (g) being a new graduate (n=1). An additional 9.6 percent (n=5) of targets who described a history of conflict between themselves and their perpetrator around their differences.

Being In the Wrong Place at the Wrong Time

For 40.3 percent (n=21) of targets, being chosen as a target of horizontal aggression occurred because they were in the wrong place at the wrong time. These targets had

done nothing to warrant their perpetrators' aggressive behaviors. Instead, these targets found themselves on the receiving end of aggression that was stimulated by another person or situation. These targets became targets because they were conveniently available to their perpetrators.

> I was simply there. Perhaps for reasons that were unknown to me she was having a bad day or wasn't feeling well or that something else was of concern (S157).
>
> I was the closest, easiest target (S052).
>
> I was the one that happened to answer the phone (S055).
>
> I just happened to be the nurse with the patient requiring a transfusion that day (S091).
>
> I was assigned to work with her that day (S121).
>
> I provided an outlet for her built up frustration (S144).

Being a Stranger

There were 26.9 percent (n=14) of targets who believed that they had become a target of their perpetrators horizontally aggressive behaviors because they were relatively unknown to their perpetrators. Reasons for this lack of familiarity were that targets were newly employed (n=6) or had been floated (n=4) to the unit where the horizontally aggressive incident took place, or that the targets worked on a different unit than their perpetrators (n=4). In all cases, respondents made safe targets for

their perpetrators aggressive behaviors because there was an absence of a past working relationship, a reduced chance of a future working relationship, and/or less opportunity for targets to retaliate.

> I was the new nurse on the ward and the other people around were her friends both inside and outside of work (P048).
>
> She did not know me therefore wouldn't have to work with me closely again (P055).
>
> I had transferred to a new location. I was the least likely to fight back (S118).
>
> I did not work directly with her on her unit therefore she could vent her frustration and anger … more easily on me than on someone she would have to work with closely (S052).

Non-confrontational Personality

There were 7.7 percent (n=4) of targets who believed that because they had a laid-back or non-confrontational personality type, and were therefore less likely to retaliate, their perpetrators found it easier to behave aggressively toward them.

Making an Error

There 3.8 percent (n=2) of targets who believed that they had become targets of their perpetrators' horizontally aggressive behaviors because they had made an error. In both cases, the targets expressed the opinion that their having made an error did not justify their perpetrators'

behavior and in fact, their perpetrators' behavior was excessive given the minor nature of the errors committed.

> She was right that I should have spoken to her before I left but I think she very much over reacted and acted in an inappropriate manner (P002).

Table 8. Reasons targets were chosen

	f	%
Being in the wrong place at the wrong time	21	40.3
Being different	21	40.3
Being a stranger	14	26.9
Being non-confrontational	4	7.7
Making an error	2	3.8

f = frequency of incidents % = percentage of incidents

Actions Taken by Targets Following an Incident of Horizontal aggression

Analysis of the quantitative and qualitative data provided by targets yielded 14 separate actions that targets took after experiencing an incident of horizontal aggression. These actions, which are summarized in Table 9 (p. 130) were as follows.

1. Talked to other nurses in the workplace (78.8 percent; n=41).

2. Avoided interacting with the perpetrator (38.5 percent; n=20).

3. Discussed the situation with the perpetrator (36.5 percent; n=19). Five of these 19 targets challenged

their perpetrator's aggressive behavior and indicated that it was inappropriate. In one of these five incidents the perpetrator acknowledged and apologized for her aggressive behavior. However, in four of these five incidents, not only did perpetrators not apologize; they subjected their target to additional aggressive behaviors. Fourteen of these 19 targets made an attempt to defended their position or explain their actions to their perpetrators. Again, these targets were subjected to additional aggressive behaviors.

4. Talked to individuals outside the institution (28.8 percent; n=15). These individuals included a spouse or a significant other (n=8), other family members (n=10), and the facility employee assistance program (n=1). In four of these 15 incidents, targets mentioned that the horizontally aggressive incident they experienced interfered with aspects of their home life.

5. Reported the incident to their supervisor (26.9 percent; n=14).

6. Talked to an individual within the institution other than a nurse (15.3 percent; n=8).

7. Took other action (9.6 percent; n=5). These actions included: (a) apologizing for making an error (n=1), (b) trying to get to know the perpetrator better

(n=1), (c) going for coffee to regroup (n=1), (d) attending a mediation meeting involving a social worker (n=1), (e) filing for abuse through labor relations (n=1), and (f) involving the Manitoba Nurses Union (n=1).

8. Did nothing (7.7 percent; n=4).

9. Behaved aggressively toward the perpetrator (7.7 percent; n=4). These behaviors included pushing the perpetrator out of the way (n=1), giving the perpetrator the silent treatment (n=1); and being rude (n=2).

10. Said nothing to anyone (5.8 percent; n=3).

11. Filled out an incident report (5.8 percent; n=3).

12. Quit the position to avoid the perpetrator (5.8 percent; n=3).

13. Took sick leave to avoid the perpetrator or to recover from the incident (3.8 percent; n=2).

14. Took vacation time to avoid the perpetrator or to recover from the incident (1.9 percent; n=1).

Table 9. Actions taken by targets after an incident

	f	%
Talked to other nurses in the workplace	41	78.8
Avoided interacting with the perpetrator	20	38.5
Discussed the situation with the perpetrator	19	36.5
Talked to individuals outside the institution	15	28.8
Reported the incident to their supervisor	14	26.9
Talked to an individual within the instituation other than a nurse	8	15.3
Took other action	5	9.6
Did nothing	4	7.7
Behaved aggressively toward the perpetrator	4	7.7
Said nothing to anyone	3	5.8
Filled out an incident report	3	5.8
Quit the position	3	5.8
Took sick leave	2	3.8
Took vacation time	1	1.9

f = frequency of incidents % = percentage of incidents

Effects of Horizontal Aggression

Analysis of the quantitative and qualitative data provided by targets yielded 25 negative effects that targets reported as resulting from the horizontally aggressive incident they had experienced. These effects were grouped into three categories as described in the following paragraphs.

Physical Effects

When asked if the horizontally aggressive behavior(s) that they had experienced had harmed them physically, 76.9 percent (n=40) of targets indicated that they had not, 19.2

percent (n=10) indicated that they had, and 3.8 percent (n=2) did not express an opinion either way. Those targets who indicated that they had been effected physically listed the five effects as listed in Table 10.

Table 10. Physical effects reported by targets

	f
disrupted sleep patterns and fatigue	5
disrupted eating patterns with nausea & loss of appetite	2
headaches	1
bronchitis	1
temproral-mandibular joint pain	1

f = frequency of incidents

Emotional Effects

When asked if the horizontally aggressive behavior(s) that they had experienced had affected them emotionally, 82.6 percent (n=43) targets indicated that it had, 7.7 percent (n=4) indicated that it had not, and 9.6 percent (n=5) did not express an opinion either way. Those targets who indicated that they had been affected emotionally listed the 16 effects listed in Table 11 (p. 132).

The duration of emotional effects ranged from less than one day to never going away. The majority of the 43 targets who reported an emotional effect (n=15) believed that the effects had lasted two to seven days. It is

important to note; however, that n=10 of the 43 targets believed that the emotional effects had never gone away.

> Even though it was seven years ago, I can't forget how rude/cruel one person can be against another (S118).

Table 11. Emotional effects reported by targets

	f
anger	13
hurt feelings	11
a loss of individual self-esteem and confidence in one's nursing abilities	9
anxious and uncomfortable around the perpetrator and in the workplace were the incident occurred for a period of time	9
created or accentuated a stressful situation making it more difficult to cope with the work day	7
offended	6
made me cry at work	6
betrayed	5
humiliated	5
fearful for their safety	3
disappointed in the perpetrator and in the profession because nurses treat each other this way	3
frustrated	2
apathetic about horizontal aggression	1
surprised	1
felt like quitting	1
depressed	1

f = frequency of incidents

Patient Care Effects

When asked if the horizontally aggressive behavior(s) that they had experienced had had a negative effect on the patient care, 23.1 percent (n=12) of targets indicated that it had; 59.6 percent (n=31) of targets indicated that it

had not; and 15.3 percent (n=8) did not express an opinion. Those targets who indicated that patient care had been affected listed five effects as listed in Table 12. While none of these effects were linked to an actual degrading of a patient's condition, all had the potential to do so.

Table 12. Patient care effects reported by targets

	f
an inability to perform extra patient care duties because time and energy was occupied in dealing with the horizontally aggressive incident or its aftermath	5
a delay in the mandatory patient care duties	3
an impaired level of concentration	3
a decrease in the caring attitude	1
impaired communications among nurses on the unit	1
refusal of nurses to assist each other with patient care tasks	4

f = frequency of incidents

CHAPTER FIVE

DISCUSSION

As in previous chapters, the research questions have been used to organize the discussion of the findings of this study.

The Existence and Frequency Of Horizontal Aggression

Existence

A large volume of anecdotal and theoretical literature that covered three decades, and included three empirical studies from the United States and Australia, indicated that horizontal aggression was a reality within nursing workplaces. The findings of this study supported this previous work, as almost one-third of respondents were able to recall and describe an incident of horizontal aggression.

Frequency

Previous work on the subject of horizontal aggression described it as a frequent occurrence among nurses (Anonymous, 1986; Ashley, 1980; Cox, 1991; Davison-Crews, 1992; Duldt, 1981; Geary Dean, 1988; Farrell, 1997; Keen, 1991; Kutlenios & Bowman, 1994; McNeil Whitehouse, 1991; Muff, 1988; Napier Skillings, 1991; Spring & Stern, 1998; Thomas & Droppleman, 1997). Spring & Stern stated that,

"horizontal aggression is rampant within the nursing profession" (p.1).

The findings of this study with respect to the frequency of horizontal aggression were divided into three groups. The first group of findings supported the literature. Targets believed that horizontal aggression occurred often on their units and throughout the workplaces of Manitoba. The second and third groups of findings were unique to this study, as no previous study had asked nurses about their own or their perpetrator's experiences around horizontal aggression. These findings suggested that the nurses in this study had rarely been the target of horizontal aggression throughout their career, but in almost half the incidents targets had been on the receiving end of horizontal aggression from the same perpetrators. In addition, targets overwhelmingly reported that their perpetrator had treated other nurses aggressively in the past. These findings would seem to suggest that perpetrators had a pattern of venting emotional tension created elsewhere onto coworkers, but that these perpetrators chose their targets because they were conveniently available or were estimated to be safe.

Individual Demographic Factors

While previous studies had described participants from a sample viewpoint, no study has elicited data on perpetrators or nurses that identified themselves as non-targets. Therefore, the findings of this study in these areas were unique. These findings were in two parts. The first was the description of the typical target, perpetrator, and non-target, and the second was the comparison and contrast of individual targets to their individual perpetrator.

Typical Demographics

The typical target and perpetrator had all but one demographic factor in common. They were female, Caucasian, and aged 30 to 39 years. Both had, as their highest level of nursing education, a nursing diploma and had been a nurse for 6 to 10 years. Both worked in a critical care area in the Winnipeg region and had been employed in their position for 91 days or more. Both worked a combination of all 3 different 8-hour shifts (days, evenings, and nights). The one factor on which the typical target and perpetrator differed was employment status. In this case, the typical target worked in a permanent position with part time hours, and the typical perpetrator worked in a permanent position with full time hours.

The typical non-target also had the majority of demographic factors in common with the typical target and perpetrator. The typical non-target was also female, Caucasian, had a nursing diploma, had been employed in their position for 91 days or more, worked a combination of the 3 different 8 hour shifts (days, evenings, nights), and worked in the Winnipeg region. Like the typical target alone, the typical non-target had a permanent position with part time hours. Unlike either the typical target or perpetrator, the typical non-target was older (aged 40 and 49 years), worked in geriatrics rather than critical care, and had been a nurse longer (31 years or more).

Comparison and Contrast Demographics

In comparing the demographic factors of individual targets with those of their perpetrator, these two individuals were very similar. In the majority of incidents, targets were the same gender and from the same ethnic background as perpetrators. The targets and her perpetrator had the same level of nursing education, the same employment status, and the same amount of employment seniority. Additionally, the target worked in the same area of nursing as her perpetrator and in the same geographical region of the province. In fact, the only demographic factors on which targets and their perpetrators differed

were age and seniority as a nurse. In the majority of incidents, a target was younger than her perpetrator and had less seniority as a nurse.

Incident Demographic Factors

In none of the studies or the articles reviewed had a horizontally aggressive incident been described beyond discussion of aggressive behaviors. These will be discussed in the next section. Therefore, the findings of this study in this area were unique.

A typical incident occurred more than 61 days ago on a day shift, was of a short duration, took place in a public location, and the target and perpetrator were in the same vicinity and in direct contact with each other. The target and perpetrator in this typical incident had often worked together prior to the incident occurring, and the target had not been floated to the area of occurrence.

Horizontally Aggressive Behaviors

No previous study had ever asked nurses to describe the specific behaviors that they had experienced during a horizontally aggressive incident. However, a variety of authors had included behaviors that they believed were indicative of horizontal aggression. These behaviors were varied and included physical and verbal types and active

and passive, direct and indirect subtypes. The majority of behaviors were verbal, active, and direct.

Thirteen of the 19 behaviors that targets in this study described as horizontally aggressive were similar to those found in the literature. These behaviors included blocking, physically attacking, being rude, non-constructive criticism, condescending, insulting, scape-goating, sabotaging, uttering threats, back-biting/gossiping, nit-picking, refusing to help, silent treatment. The remaining six behaviors were unique to this study (physically dismissing, throwing objects, not providing patient coverage, intimidating, verbally dismissing, and cursing). All 19 behaviors were categorized using Buss's typology of aggression. Like those behaviors described in the literature, the behaviors in this study were varied and included physical and verbal types and active and passive, direct and indirect subtypes. Also, as in the literature, the majority of behaviors in this study were verbal, active, and direct. It is interesting to note that the majority of incidents involved more than one aggressive behavior.

Four behaviors (tripping, betraying a confidence, non-defense, and excluding from group activities) that were discussed in the literature were not found in this study.

However, it cannot be assumed that these behaviors do not exist or are not horizontal aggression. All that can be said is that these behaviors were not present in the incidents described by the targets who selected to participate in this study.

Antecedent Factors

No previous study had asked nurses to identify specific factors that they believed were antecedents to horizontal aggression. Therefore, the findings of this study in this area were unique. Two of the three previous studies (McCall, 1996; Napier Skillings, 1992) and the large volume of theoretical and anecdotal literature described women's/nurses' oppression as responsible for horizontal aggression, but none of the targets in this study specifically identified oppression as an antecedent factor. However, the factors that were identified (excessive workloads, rivalries, perpetrator personal stress, a negative perpetrator reputation, and using the target to boost one's self-esteem) supported aspects of the conceptual model and will be discussed subsequently. It is of interest to note that in many incidents more than one antecedent factor was identified.

Reasons Targets Were Chosen

In one previous study, Napier Skillings (1992) found that her participants believed they had become targets of horizontal aggression because they were different than their perpetrator. These differences included being new (newly graduated or new to a work unit) or being different with respect to race, gender, and/or sexual orientation. The theoretical and anecdotal literature also described differences as the reason nurses were chosen as targets, but added to Napier Skillings criteria the facets of educational entry to practice (diploma versus university degree), specialization, and approach to practice (traditional versus research based).

The findings of this study included five categories of reasons that nurses believed they became targets of horizontal aggression. One of these categories of reasons, being different, supported the previous work in this area, but four were unique to this study (being in the wrong place at the wrong time, being a stranger, being non-confrontational, and making an error). These four categories of reasons supported aspects of the conceptual model which will be discussed later in this chapter. The relationship between being different and the conceptual model is not clear; therefore this category of reasons for

becoming a target of horizontal aggression will be discussed here. It is of interest to note that in many incidents more than one reason was identified.

Like the findings on being different in Napier Skillings (1992) study, having a different ethnic background and being a new graduate were found in this study. However, five other criterion for being different were identified in this study, and they included (a) having a different personal and/or professional belief system (a clash of values and attitudes); (b) having more position seniority; (c) having more or less experience as a nurse; and (d) being younger. These latter two factors were evident in the targets of this study who tended to be younger and have less seniority than their perpetrators.

Actions Taken by Targets Following an Incident of Horizontal Aggression

No previous study had asked nurses to describe actions they had taken after experiencing a horizontally aggressive incident. Previous studies had found that the occurrence of horizontal aggression was under-reported (Farrell, 1997; McCall, 1996; Napier Skillings, 1991). Napier Skillings found nurses who reported episodes of horizontally aggressive behavior to their supervisors, or through formal

employee grievance procedures, were unsupported, unbelieved, and/or labeled as "trouble-makers".

The theoretical and anecdotal literature described actions that authors believed targets of horizontal aggression might take following an incident. These actions included calling in sick, changing shifts, leaving positions, and even leaving the profession to avoid aggressive individuals, to escape hostile work environments, and/or to recover from the effects of an aggressive incident (Cox, 1991; Farrell, 1997; Napier Skillings, 1991; Nelson, 1995; Thomas & Droppleman, 1997).

The findings in this study included 13 actions. Four of these actions were similar to those described in the literature. These actions included quitting a position, taking vacation or sick leave, and avoiding interaction with the perpetrator. The remaining nine actions were unique to this study and included the following.

1. Targets discussed the situation with other nurses, other individuals in the workplace, family members, and/or the perpetrator. This latter action most often netted targets additional aggressive behavior from their perpetrator.

2. Targets acted aggressively toward their perpetrator.

3. Targets reported the incident verbally through official channels or by filling out an incident report.

4. Targets did and said nothing.

Effects of Horizontal Aggression

The three previously cited studies found that nurses who had experienced horizontal aggression found it to be painful, and the emotional discomfort lasted for days, months, or even years (Farrell, 1997; McCall, 1996; Napier Skillings, 1991). The literature described horizontal aggression as a source of workplace stress and job dissatisfaction for nurses as well as an intensifier of other workplace stress (Nelson, 1995). Other authors indicated that horizontal aggression had the potential to impact patient care either because the horizontal aggressive incident, and/or its aftermath, wasted time, energy, and resources or because nurse peers refused to assist each other with patient care tasks (Anonymous, 1986; Duffy, 1995; Farrell; Hilton, 1993; Nelson).

The findings in this study included individual physical and emotional effects for targets of horizontal aggression, and potential effects for patient care.

Physical Effects

No previous work had identified physical effects of horizontal aggression for targets. The five physical

effects found in this study were primarily stress related and included headaches, muscular pain, opportunistic infections, and disrupted eating and sleeping patterns.

Emotional Effects

This study yielded 16 emotional effects for targets. Like previous studies, this study found hurt feelings was a common effect. Like previous literature, this study found that horizontal aggression intensified stress in the workplace and made it more difficult to cope with stressors. The remaining 14 emotional effects were unique to this study.

The majority of targets in this study reported that their emotional effects lasted two to seven days, but almost 20 percent reported that the effects never subsided. This latter finding was in keeping with previous studies.

Patient Care Effects

This study yielded five effects that targets indicated had the potential to negatively impact patients and degrade their health status. Like findings reported in the literature, this study found that targets believed that horizontal aggression, and/or its aftermath, wasted time, energy, and resources which decreased the amount of these entities for routine and extra patient care. As was discussed in the earlier section on aggressive behaviors,

and mentioned in the literature, the refusal of nurses to assist each other with patient care tasks was also found in this study. The other four effects were particular to this study and included targets being delayed in providing patient care, having an impaired level of concentration, having a decreased caring attitude, and having impaired communications with other nurses on the unit.

Limitations of Findings

This study was designed to elicit descriptive data on the phenomenon of horizontal aggression, and it has done this admirably. However, it must be acknowledged that there were limitations of the study. The first limitation was that this study was non-experimental in nature; and therefore, its findings cannot be generalized to a wider population. Generalization is further hampered by the fact that the number of nurses who responded to the survey and identified themselves as a target of horizontal aggression was only about three percent of the entire general duty/staff nurse population in Manitoba. It cannot be concluded that the findings in this study reflect the opinions of the entire population, represent all of the possible responses that exist, or represent the number of nurses who have experienced horizontal aggression. Rather,

it is assumed that the findings of this study represent "the tip of the iceberg" about horizontal aggression.

The second limitation was that data on perpetrators of horizontal aggression was provided solely by targets; therefore, it must be remembered that the findings represent the beliefs of targets alone.

The Conceptual Model

The purpose of this study was to increase the empirical knowledge on the concept of horizontal aggression among nurses. The conceptual model used in this study was constructed by the author and flowed out of the review of the literature on women's/nurses' oppression in the patriarchal society and its health care system. In this model, horizontal aggression was positioned as an end-state behavioral response to this oppression. This study, and the survey it used, focused on horizontal aggression and did not elicit respondent's beliefs about oppression, about its link to horizontal aggression, or about other concepts included in the model. Despite these facts, many of the findings of this study, particularly the antecedent factors and reasons that targets were chosen supported different concepts of the model. These concepts will be discussed.

Characteristics of Oppression

The characteristics of oppression included internalization, assimilation, and marginalization. Support for internalization and assimilation was found in this study.

Internalization. The first finding that supported the characteristic of internalization was the antecedent factor subcategory of a negative perpetrator reputation. Previous authors had suggested that women/nurses were quick to blame horizontally aggressive behaviors on individual perpetrator personality traits. By doing so, it was hypothesized that individuals had internalized the patriarchal myth that oppression did not exist, which allowed individuals to ignore and/or deny that they were oppressed and justified their inaction toward challenging or changing their oppressive reality (Ashley, 1980; Duffy, 1995; Farrell, 1997; Keen, 1991; McCall, 1996; Muff, 1988; Napier Skillings, 1991; Roberts, 1983; Spring & Stern, 1998; Droppleman & Thomas, 1996). The inability of oppressed groups to get past blaming each other rather than the oppressor marks them as oppressed (Freire, 1970).

The second finding that supported the characteristic of internalization was the antecedent factor entitled: If you look bad, I look better. Keen (1991) and McNeil

Whitehouse (1991) both described nurses that made themselves feel superior by making other nurses feel inferior, and indicated that this behavior was evidence of internalization.

Assimilation. The first finding that supported the characteristic of assimilation was the horizontally aggressive behavior of sabotage. The literature described sabotage as evidence of assimilation (Baker Miller, 1986; Wilson Schaef, 1992).

The second finding that supported the characteristic of assimilation was the antecedent factor subcategory of inter- and intra-unit rivalries. Rivalries between units and nurses more organized around the medical model of cure (intensive care areas and operating rooms) than around the nursing concept of care (palliative, medical, or geriatrics) were proposed by Keen (1991) as evidence of assimilation. In this study, targets identified inter-unit rivalries between critical care areas including emergency and nursing wards and between nurses working in labor and delivery and postpartum wards.

The third finding that supported the characteristic of assimilation was the antecedent factor of being bossy and needing to be in control which was contained in the subcategory of a negative perpetrator reputation. Authors

described these types of nurses as having assimilated the dominant culture of the patriarchal society because they now equate success with being able to "boss" others particularly if those others are members of the oppressed group (Freire, 1970; McCall, 1996; Roberts, 1983).

Submissive-Aggressive Syndrome

The first finding that supported the existence of the submissive-aggressive syndrome was the antecedent factors of environmental and perpetrator issues. Factors in the nursing environment or within perpetrators created emotional tension for perpetrators. These perpetrators vented this tension by behaving aggressively towards the target-- another nurse--rather than toward the individuals/situations that created the environmental issues. This finding mirrors the literature that suggested that because of submissiveness, women/nurses prefer to vent emotions such as anger and frustration onto other women/nurses whom they see as safe targets rather than directly expressing these emotions toward the forces responsible for oppression and/or use these emotions to effect change.

As one target wrote about excessive workloads:

> There is an inability to meet standards and blaming of co-workers instead of the circumstances [that created the excessive workloads] (S057).

The second finding that supported the existence of the submissive-aggressive syndrome was the fact that targets reported their perpetrators had a history of treating other nurses aggressively but that targets experienced horizontal aggression only rarely. This finding supports the premise of the model that nurses have adopted a cyclical pattern of suppression of emotions alternated with occasional venting towards a target that is chosen for safety and/or convenience sake.

Four other findings also supported the existence of the submissive-aggressive syndrome. These findings were the categories of reasons why targets were chosen as targets of horizontal aggression entitled: (a) being in the wrong place at the wrong time, (b) being a stranger, (c) being non-confrontational, and (d) making an error. In the first three categories, nurses did nothing to trigger their perpetrators aggression beyond being convenient (being in the wrong place…) or a safe target (being a stranger and being non-confrontational). In all cases, perpetrators vented the emotional tension created by other individuals or situations by behaving aggressively toward the target.

In the fourth category, making an error, the target did something that triggered her perpetrators aggression;

however, the perpetrators' behavior was excessive given the minor nature of the errors committed. This imbalance between the trigger of aggression and the behavioral response was described in the literature as evidence of the submissive-aggressive syndrome. Authors suggested that because of submissiveness, emotional responses to oppression were suppressed over time until some event, often a minor infraction, acted as "the straw that broke the camels back" and triggered the catharsis of all the suppressed emotions not just those emotions caused by the infraction.

Implications for Nursing

The findings of this study have implications for nursing practice, administration, education, and research.

Practice

Horizontal aggression among nurses is a practice issue, and it is impacting the private and professional lives of practicing nurses. As Freire (1970) indicated, to overcome oppression requires a grassroots movement among those that are oppressed. Therefore, only nurses can put a stop to horizontal aggression by overcoming the oppression that causes it.

Administration

Nurses work for nursing administrators. Therefore, these administrators have a duty to be aware of the existence of horizontal aggression and be able to recognize it. Nurse administrators must believe nurses when they report horizontal aggression, deal with perpetrators appropriately, and set the example by not behaving in a horizontally aggressive manner or tolerating it in others.

Education

Spring and Stern (1998) described horizontal aggression as a pattern of behavior toward nursing peers that has been passed from one generation to the next through professional socialization. The formal education process for nurses is a major part of their professional socialization; thus, it represents the ideal time and place to break a pattern of behavior that has existed for some time.

Research

Despite a volume of theoretical and anecdotal literature, the oppression of nurses, and its outcomes including horizontal aggression, has only begun to be studied. Napier Skillings and Farrell (1997) recommended testing the link between oppression and horizontal aggression. To do this will require hypotheses testing to

determine the accuracy of the conceptual model and the relationship between and among its concepts.

Many other questions were raised during this study. Some of them included:

1. How are male nurses different from female nurses with respect to oppression and its outcomes including horizontal aggression?

2. How does nursing differ from other female dominated occupations with respect to horizontal aggression?

3. Does horizontal aggression exist in occupations that are not gender dominated?

4. Do physicians believe that medicine is an oppressive force for nurses?

5. What interventions could decrease or eliminate oppression and horizontal aggression for nurses?

Summary

The findings of this descriptive study indicated that targets believed that horizontal aggression was a frequently occurring phenomenon in nursing workplaces. Targets reported that they had rarely been a target of horizontal aggression, but that their perpetrators had a pattern of behaving aggressively and choosing targets who were conveniently available or judged to be a safe target.

The findings of this study increased the descriptive data available on the phenomenon of horizontal aggression and on those nurses who were targets, perpetrators, and non-targets. In this study, targets and perpetrators were very similar except that perpetrators worked more hours each week. Non-targets were very similar to targets and perpetrators except that non-targets were older, had more seniority as nurses, and worked in geriatrics versus a critical care unit. When comparing an individual target to her perpetrator, the majority of targets were younger and had less seniority as a nurse.

The types of behaviors that targets experienced under the definition of horizontal aggression were physical and verbal, active and passive, and direct and indirect. The majority of targets experienced verbal, active, and direct aggression from their perpetrator. The most common verbal behaviors included being rude and non-constructive criticism.

Antecedent factors and reasons why targets were chosen were illuminated in the findings of this study, and many of these factors and reasons supported the concepts internalization, assimilation, and the submissive-aggressive syndrome from the conceptual model of women's/nurses' oppression.

Findings from this study also indicated that targets of horizontal aggression took specific actions following an incident of aggression. In some cases, these actions were active attempts to deal with the incident and in others, they were passive attempts to avoid the situation.

Finally, the findings of this study indicated that horizontal aggression had physical and emotional effects for nurses. The findings also indicated that horizontal aggression had the potential to negatively impact patient care.

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APPENDIX A

COVER LETTER TO THE SURVEY

THE UNIVERSITY OF MANITOBA FACULTY OF NURSING Winnipeg, Manitoba Canada R3T 2N2

Tel: (204) 474-7452
Fax: (204) 474-7682

Gayle Quick
776 School Road
Winnipeg, MB R2Y 0S5

February, 1999

Dear Registered Nurse,

My name is Gayle Quick. I am a student in the Master's of Nursing Program at the University of Manitoba. As part of my program, I am conducting a study entitled *Horizontal Aggression among General Duty/Staff Registered Nurses in Manitoba: A Descriptive Study*. Horizontal aggression is a type of workplace aggression in which one registered nurse behaves aggressively toward another. Little is known about this form of aggression, and this study is intended to address this lack of knowledge.

To assist me with this study, I am requesting approximately 30 minutes of your time to complete a survey on an incident of horizontal aggression that you may have experienced in your work life. The Ethical Review Committee of the Faculty of Nursing has approved this study for research purposes, and the Manitoba Association of Registered Nurses (MARN) has approved it for access to its

membership list. Your name was chosen randomly from the 1999 registration data bank by the staff at MARN, who then addressed and mailed this survey to you.

Participation in this project is entirely voluntary. You are under no obligation to participate and may withdraw from the study at any time. By completing and returning the survey in the enclosed addressed and stamped envelope, you are agreeing to take part in the study. As your name does not appear on the survey or the return envelope, your identity remains completely anonymous. Please do not place your name or any other identifying marks on the survey or the envelope. All the data you provide will remain strictly confidential. The only people with access to it will be myself, the members of my thesis committee (Dr. Erna Schilder, Ms. Linda Hughes, and Dr. Dickie Yu), and, if necessary, a statistician from the Manitoba Nurses' Research Institute. Completed surveys will be kept locked in a filing cabinet for a period of seven years, and then they, plus any data existing in electronic form, will be destroyed.

On completion of this study, a research report will be submitted to a variety of journals for publication. If you would like a summary of this report mailed to you, refer to the *Request For Summary Report* form that has been included with this survey package and follow the instructions it provides for returning your request.

If you have any questions regarding this study, please contact my thesis committee chair, Dr. Erna Schilder, by phoning (204)-474-8218. If you find that completing the survey raises feelings that are upsetting or distressing,

you may wish to discuss your experiences with horizontal aggression further. Two possible resources are the Employee Assistance Program (EAP) within your facility or the Crisis Line at Klinic Community Health Centre 1-888-322-3019.

Thank you in advance for your participation. A reminder letter will be mailed to you in two weeks. If you have already completed and returned your survey when this letter arrives, please ignore it. If you have not completed the survey when this letter arrives, please reconsider participating in the study?

Sincerely,

Gayle Quick RN, BN

APPENDIX B

GENERAL DUTY/STAFF REGISTERED NURSES
HORIZONTAL AGGRESSION SURVEY

Subject Number: _____

TO ENSURE THE CONFIDENTIALLITY OF THE INFORMATION YOU PROVIDE, PLEASE
DO NOT WRITE YOUR NAME OR ANY OTHER IDENTIFYING INFORMATION ON THIS SURVEY.

General Instructions

For the purpose of this study, horizontal aggression is defined as aggressive behavior that one general duty/staff registered nurse commits against another in the workplace. This aggressive behavior can be verbal, such as name calling or making threats; non-verbal, such as a cold stare or making faces; or physical, such as pushing. This behavior can be expressed directly toward another person or indirectly toward their property or work. The behavior can be expressed openly or in a hidden manner. In any case, if this same behavior were directed at a patient or another health care employee, it would be seen as inappropriate and unprofessional.

Please reflect on the **most recent** incident in which another general duty/staff registered nurse treated you in a manner that fits with the definition of horizontal aggression provided above. With this incident in mind, complete the survey and return it in the large stamped and addressed envelope provided. Please do not comment on aggressive behavior you may have experienced from other sources such as a nurse manager, a nurse educator, a physician, or from another non-registered nurse health care employee.

If you **are unable** to recall any incident in your career that matches the definition above, leave this survey blank and complete the demographic sheet included in this survey package. Return both the blank survey and the completed demographic sheet in the large stamped and addressed envelope provided. Please fill out either the survey or the demographic sheet but not both.

Should you require additional space to answer any question in the survey, or if you would like to provide additional comments about horizontal aggression or your experiences in completing this survey, feel free to attach additional pages to this survey.

Thank you for your participation.

Part One

1. In your own words, describe the **most recent** incident in which another general duty/staff registered nurse treated you in a manner that fits with the definition of horizontal aggression provided on page one of this survey. Please only describe the details of this one incident that occurred between you and the other general duty/staff registered nurse. Do not comment on aggressive behavior you may have experienced from other sources such as a nurse manager, a nurse educator, a physician, or from another non-registered nurse health care employee.

2. Why do you think the incident that you have just described occurred?
What factors led up to it?

3. Why do you think you were chosen as the target of the incident you have just described?

Part Two

Circle the number that best describes your response to the following questions and statements. Where indicated, please provide additional written comments.

1. How long ago did the incident you described in Part One of this survey took place?

7 days or less ago	1
8 - 14 days ago	2
15 - 21 days ago	3
22 - 28 days ago	4
29 days - 60 days ago	5
61 days or more ago	6
Unsure	7

2. What action(s) did you take after the incident you described in Part One of this survey took place? (Circle all that apply)

I said nothing to anyone.	1
I did nothing.	2
I reported the incident to my supervisor.	3
I filled out an incident report.	4
I discussed the situation with the other general duty/staff registered nurse involved.	5
I avoided interacting with the other general duty/staff registered nurse involved.	6
I took vacation time to avoid the other general duty/staff registered nurse involved or to recover from the incident.	7
I took sick leave to avoid the other general duty/staff registered nurse involved or to recover from the incident.	8
I changed shifts to avoid the other general duty/staff registered nurse involved.	9
I quit my position to avoid the other general duty/staff registered nurse involved.	10
I talked to other general duty/staff registered nurses about the situation.	11
I talked to someone else within the institution about the situation. (specify position)	12
I talked to someone outside the institution about the situation. (specify position)	13
I behaved aggressively toward the other general duty/staff registered nurse involved. (specify how)	14
I took other action(s). (specify what)	15

3. The general duty/staff registered nurse that behaved aggressively towards me in the incident I described in Part One of this survey committed the following behavior(s). (Circle all that apply)

Physical contact: She/he hit, slapped, punched, kicked, bit, or made other physical contact with me in order to inflict harm.	1
Blocking: She/he refused to move out of my way.	2
Nit-picking: She/he excessively checked my work, without cause, for errors and/or omissions.	3
Sabotage: She/he purposely undermined my actions or damaged my reputation.	4
Tripping: She/he purposely tripped or set an obstacle in my path.	5
Inassistance 1: She/he refused to assist me even with a necessary patient task.	6
Inassistance 2: She/he refused to complete a necessary patient task for me when I was temporarily absent from the work area.	7
Betrayal: She/he told others information I had given to her/him in confidence even though I asked her/him not to.	8
Bickering: She/he argued with me in front of other people.	9
Condescension: She/he responded verbally or in writing (leaving notes) to my questions, concerns, or comments in a sarcastic or condescending manner.	10
She/he criticized, without cause, my method of implementing nursing interventions because they were different than hers/his or the traditional practice of the work area.	11
She/he criticized, without cause, the quantity of my work such as the number and/or acuity of patients or the number of hours/shifts/weekends worked.	12
Name-calling: She/he insulted me to my face (with or without other people being present).	13
Uttering threats: She/he threatened to behave aggressively toward me.	14
She/he yelled at me in front of other individuals.	15
Back-biting: She/he made insulting comments about me in front of other people when I was not present to defend myself.	16
Gossiping: She/he created and/or spread hurtful falsehoods about me.	17
Scape-goating: She/he blamed me, with or without proof, for errors, omissions, and/or problems in front of others when I was not present to defend myself.	18

Two-faced: She/he acted as a friend and confidant in my presence but betrayed, insulted, and/or gossiped about me in my absence.	19
Information hoarding: She/he purposely withheld information to detrimentally effect my career.	20
Silent Treatment: She/he refused to speak with me even about work related matters.	21
Social Isolation: She/he purposely excluded me from team activities such as going for coffee breaks.	22
She/he did not speak-up in my defense when others engaged in backbiting, name-calling, gossiping, etc..	23
She/he directed hostile, non-verbal communications at me such as a cold Shoulder, an icy stare, and/or a chilly silence.	24
None of the above labels fit. I would give it the following name.	25

4. On what shift were you working when the incident you described in Part One of this survey took place?

8 hour day shift	1
8 hour evening shift	2
8 hour night shift	3
12 hour day shift	4
12 hour night shift	5
Other (please specify)	6

5. I believe that the incident I described in Part One of this survey harmed me physically.

strongly disagree	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

If you responded with Agree (4) or Strongly Agree (5) please specify what harm was done.

_____

6. I believe that the incident I described in Part One of this survey affected me emotionally (example: hurt my feelings, made me angry, made me cry etc.).

strongly disagree	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

If you responded with Agree (4) or Strongly Agree (5) please specify what affect the incident had.

If you responded with Agree (4) or Strongly Agree (5), please rate how long this emotional affect lasted.

less than 1 day	1
2-7 days	2
8 - 28 days	3
29 days - 60 days	4
greater than 61 days but the feelings eventually went away	5
the feelings never went away	6
Unsure	7

7. I believe that the patient care I was expected to deliver was affected as a result of the incident I described in Part One of this survey.

strongly disagree	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

If you responded with Agree (4) or Strongly Agree (5) please specify in what way patient care was affected.

---

8. The general duty/staff registered nurse that behaved aggressively towards me in the incident I described in Part One of this survey had never treated me in an aggressive manner before.

strongly disagree	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

9. The general duty/staff registered nurse who behaved aggressively toward me in the incident I described in Part One of this survey had never treated other general duty/staff registered nurses aggressively.

strongly disagree	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

10. I believe that the aggressive behavior I described in Part One of this survey was done intentionally by the other general duty/staff registered nurse to inflict harm on me.

	1
disagree	2
neither agree nor disagree/I don't know	3
agree	4
strongly agree	5

11. How frequently do you think horizontal aggression among general duty/staff registered nurses occurs on the unit where the incident you described in Part One of this survey took place?

rarely	1
sometimes	2
often	3
very often	4

12. How frequently do you think horizontal aggression among general duty/staff registered nurses occurs in the hospital where the incident you described in Part One of this survey took place?

rarely	1
sometimes	2
often	3
very often	4

13. How frequently do you think horizontal aggression among general duty/staff registered nurses occurs in the province of Manitoba?

rarely	1
sometimes	2
often	3
very often	4

14. How frequently have you been the target of horizontal aggression from another general duty/staff registered nurse throughout your career?

rarely	1
sometimes	2
often	3
very often	4

Part Three

Please circle the number that best describes your response to the following questions about yourself and the other general duty/staff registered nurse that behaved aggressively toward you in the incident you described in Part One of this survey.

1. What is your gender and that of the other general duty/staff registered nurse involved in the incident you described in Part One of this survey?

	You	Other Registered Nurse
female	1	1
male	2	2

2. What is your ethnic background and that of the other general duty/staff registered nurse involved in the incident you described in Part One of this survey?

	You	Other Registered Nurse
Caucasian	1	1
Native	2	2
Metis	3	3
Asian	4	4
other	5	5
unsure		6

3. At the time of the incident you described in Part One of this survey, what were your age group and that of the other general duty/staff registered nurse?

	You	Other Registered Nurse
20 - 25 years	1	1
26 - 29 years	2	2
30 - 39 years	3	3
40 - 49 years	4	4
50 - 59 years	5	5
60 - 69 years	6	6
unsure		7

4. At the time of the incident you described in Part One of this survey, what were the highest level of nursing education you and the other general duty/staff registered nurse had achieved.

	You	Other Registered Nurse
Registered Nurse diploma	1	1
Baccalaureate degree (BN/BScN)	2	2
Masters degree	3	3
unsure		4

5. At the time of the incident you described in Part One of this survey, for how many years had you and the other general duty/staff registered nurse been a registered nurse?

	You	Other Registered Nurse
less than 1 year	1	1
1 - 5 years	2	2
6 - 10 years	3	3
11 - 15 years	4	4
16 - 20 years	5	5
21 - 25 years	6	6
26 - 30 years	7	7
31 years or more	8	8
unsure		9

6. At the time of the incident you described in Part One of this survey, in what region of the Province were you and the other general duty/staff registered nurse working?

	You	Other Registered Nurse
Winnipeg	1	1
Burntwood	2	2
Central	3	3
Interlake	4	4
Marquette	5	5
Norman	6	6
North Eastman	7	7
Parkland	8	8
South Eastman	9	9
South Westman	10	10
unsure		11

7. At the time of the incident you described in Part One of this survey, what area of nursing were you and the other general duty/staff registered nurse working?

	You	Other Registered Nurse
cancer care	1	1
clinic/ambulatory	2	2
critical care	3	3
emergency	4	4
geriatric/long term care	5	5
maternal/newborn	6	6
medicine	7	7
mental health/psychiatry	8	8
neurology	9	9
oncology	10	10
operating room	11	11
orthopedics	12	12
palliative care	13	13
pediatric care	14	14
rehabilitation	15	15
surgery	16	16
women's health	17	17
other (Please specify)	18	18
unsure		19

8. Had you or the other general duty/staff registered nurse been floated to the area were the incident you described in Part One of this survey took place?

	You	Other Registered Nurse
yes	1	1
no	2	2
unsure		3

9. At the time of the incident you described in Part One of this survey, how frequently had you worked with the other general duty/staff registered nurse before?

never	1
rarely	2
sometimes	3
often	4
very often	5

10. At the time of the incident you described in Part One of this survey, what combination of shifts were you and the other general duty/staff registered nurse working?

	You	Other Registered Nurse
only 8 hour days	1	1
only 12 hour days	2	2
only 8 hour evenings	3	3
only 8 hour nights	4	4
only 12 hour nights	5	5
combination of two different 8 hour shifts (days and evenings/days and nights/evenings and nights)	6	6
both 12 hour shifts	7	7
combination of all three 8 hour shifts (days, evenings, nights)	8	8
unsure		9

11. At the time of the incident you described in Part One of this survey, what were your employment status and that of the other general duty/staff registered nurse?

	You	Other Registered Nurse
permanent position full time	1	1
permanent position part time	2	2
term position full time	3	3
term position part time	4	4
casual position working full time hours	5	5
casual position working less than full time hours	6	6
other (please specify)	7	7
unsure		8

12. At the time of the incident you described in Part One of this survey, how long had you and the other general duty/staff registered nurse been employed in the position you indicated in Question 11?

	You	Other Registered Nurse
14 days or less	1	1
15 to 30 days	2	2
31 to 60 days	3	3
61 to 90 days	4	4
91 days or more	5	5
Unsure		6

Demographic Sheet

Subject Number: _____

TO ENSURE THE CONFIDENTIALITY OF THE INFORMATION YOU PROVIDE, **DO NOT WRITE** YOUR NAME OR ANY OTHER IDENTIFYING INFORMATION ON THIS SHEET.

General Instructions

This sheet is to be completed only by those individuals unable to recall any incident in which they were the targets of horizontal aggression from another general duty/staff registered nurse. Once completed, this sheet should be returned along with the blank copy of the survey in the large stamped and addressed envelope provided.

1. What is your gender?

Female	1
Male	2

2. What is your ethnic background?

Caucasian	1
Native	2
Metis	3
Asian	4
Other	5

3. What is your age group?

20 - 25 years	1
26 - 29 years	2
30 - 39 years	3
40 - 49 years	4
50 - 59 years	5
60 - 69 years	6

4. What is your highest level of nursing education?

Registered Nurse Diploma	1
Baccalaureate Degree (BN/BScN)	2
Masters Degree	3

5. For how many years have you been a registered nurse?

less than 1 year	1
1 - 5 years	2
6 - 10 years	3
11 - 15 years	4
16 - 20 years	5
21 - 25 years	6
26 - 30 years	7
31 years or more	8

6. In what geographical area do you work?

Winnipeg	1	1
Burntwood	2	2
Central	3	3
Interlake	4	4
Marquette	5	5
Norman	6	6
North Eastman	7	7
Parkland	8	8
South Eastman	9	9
South Westman	10	10

7. In what area of nursing are you working?

cancer care	1
clinic/ambulatory	2
critical care	3
emergency	4
geriatric/long term care	5
maternal/newborn	6
medicine	7
mental health/psychiatry	8
neurology	9
oncology	10
operating room	11
orthopedics	12
palliative care	13
pediatric care	14
rehabilitation	15
surgery	16
women's health	17
other area (Please specify)	18

8. Do you work as a member of a float pool?

yes	1
no	2

9. What is your employment status?

Permanent position full time	1
Permanent position part time	2
Term position full time	3
Term position part time	4
Casual position working full time hours	5
Casual position working less than full time hours	6
Other (please specify)	7

10. How long have you been employed in your present position?

14 days or less	1
15 to 30 days	2
31 to 60 days	3
61 to 90 days	4
91 days or greater	5

11. What combination of shifts do you work?

only 8 hour days	1	1
only 12 hour days	2	2
only 8 hour evenings	3	3
only 8 hour nights	4	4
only 12 hour nights	5	5
combination of two different 8 hour shifts (days and evenings/days and nights/evenings and nights)	6	6
both 12 hour shifts	7	7
combination of all three 8 hour shifts (days, evenings, nights)	8	8

APPENDIX C

REQUEST FOR SUMMARY REPORT

If you would like a summary of the research report mailed to you at the end of the study, please complete the form at the bottom of this page and seal it into the white addressed envelope provided for this purpose. You can then either return this sealed envelope with your survey or mail it separately. The envelope will not be opened until the study is completed and the summary is written. Therefore, in no way can your identity be linked with the answers you have provided on the survey. If the address you provide below is your home address, your name is not required. However, if the address you provide is your work address, you must include your name so that the summary, once mailed, can reach you. Again thank you for participating in this study.

(Tear off and return in envelope provided)

Name (optional): _____

Address: _____

_____

_____

_____

APPENDIX D

SURVEY REMINDER LETTER

Gayle Quick
776 School Road
Winnipeg, MB R2Y 0S5

February, 1999

Dear Registered Nurse,

Approximately two weeks ago, you should have received a survey package in the mail that requested your participation in a nursing research study entitled *Horizontal Aggression Among General Duty/Staff Registered Nurses in Manitoba.*

If you have completed and returned the survey or demographic sheet enclosed in the survey package, I thank you. If you are still undecided, please reconsider participating. Surveys will be accepted for inclusion in the study up to March 15, 1999. If you did not receive a survey and you would like to participate, please call me collect at 204-885-3746.

Thank you in advance for your participation.

Sincerely,

Gayle Quick RN, BN

APPENDIX E

UNIVERSITY OF MANITOBA
FACULTY OF NURSING ETHICAL APPROVAL

The University of Manitoba

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number #98/51

Proposal Title: "Horizontal Aggression Among Manitoba General Duty Registered Nurses: A Descriptive Study"

Name and Title of Researcher(s): Gayle Quick
Date of Review: November 4,1998

APPROVED BY THE COMMITTEE: November 19, 1998

Comments: With changes and clarifications dated November 6, 1998

Date: November 19, 1998

Barbara Naimark

Dr. Barbara Naimark, Chair

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

APPENDIX F

MARN ETHICAL APPROVAL

Manitoba Association of Registered Nurses
647 Broadway, Winnipeg, Manitoba R3C 0X2 (204) 774-3477
Toll Free: 1-800-665-2027 (Manitoba only.)
Fax: (204) 775-6052

Gail Quick
776 School Road
Winnipeg, MB R2Y 0S5

December 3, 1998

Dear Gail,

I have received your application for access to MARN membership for your study: *Horizontal Aggression Among Manitoba General Duty Registered Nurses: A Descriptive Study.* Your project promises to contribute to our understanding of an issue which is of importance to MARN. There are a few points which need to be addressed before we can provide the requested service.

1) Your proposal refers to changes being made to the survey following the pilot study. These changes must be submitted to MARN for review prior to mailing surveys to members.

2) In your letter to members there is reference to the MARN *Nurses at Risk Program.* This program has evolved to one that will be focused on registered nurses working with practice standards in a positive practice environment. You will need to specify alternative resources.

3) Your letter to members indicates in a single sentence that the study is approved by the MARN and the Ethical Review Committee of the Faculty of Nursing. It would be preferred that you stated that the MARN approved the study for access to membership, and included the statement you have regarding MARN's role and protection of members confidentiality.

4) Attached is a copy of the MARN registration form, Section C. Your request for a random sample needs to be generated using the categories in this section. Please confirm that it is members in part 17, Section I, Direct Patient Care that you wish to include in the sample.

Once the above changes are made, MARN would be pleased to label and mail your surveys. Attached please find a copy of the MARN policy *Release of Information.* As you know, our membership renewal is in progress. We will be able to accommodate your request in the New Year. Please feel free to contact Marta Crawford if you have any questions.

Sincerely

M Crawford for Dee Nelson, R.N.

Marta Crawford
Consultant, Practice of Nursing

APPENDIX G

DEMOGRAPHIC DATA

Respondent / Incident	Targets		Perpetrators		Non-Targets	
	f/% (52/100)		f/% (52/100)		f/% (116/100)	
Gender						
female	51	98.1	50	96.2	112	96.6
male	1	1.9	2	3.8	4	3.4
Ethnic Background						
Caucasian	47	90.3	44	84.6	109	94.0
Native	0	0	1	1.9	0	0
Metis	2	3.8	0	0	2	1.7
Asian	2	3.8	2	3.8	2	1.7
other	1	1.9	4	7.7	3	2.6
unsure	-	-	1	1.9	-	-
Age						
20 - 25 years	3	5.8	0	0	3	2.7
26 - 29 years	11	21.1	5	9.6	9	7.8
30 - 39 years	20	38.5	24	46.2	24	20.6
40 - 49 years	10	19.2	13	25.0	50	43.1
50 - 59 years	8	15.3	7	13.5	27	23.3
60 - 69 years	-	-	1	1.9	3	2.6
unsure	-	-	2	3.8	-	-
Nursing Education						
Diploma	44	84.6	43	82.6	99	85.3
BN/BscN	7	13.5	5	9.6	15	12.9
MN	-	-	-	-	2	1.7
unsure	1	1.9	4	7.6	-	-
Seniority (RN)						
less than 1 year	1	1.9	2	3.8	1	0.9
1 - 5 years	7	13.5	3	5.8	1	0.9
6 - 10 years	15	28.8	12	23.1	8	6.9
11 - 15 years	9	17.3	5	9.6	14	12.1
16 - 20 years	7	13.5	6	11.5	21	18.1
21 - 25 years	6	11.5	5	9.6	14	12.1
26 - 30 years	5	9.6	4	7.7	18	15.5
31 years or more	1	1.9	2	3.8	26	22.4
unsure	1	1.9	13	25.0	13	11.2
Employment Status						
permanent position full time hours	18	34.6	26	50.0	30	25.9
permanent position part time hours	29	55.8	16	30.8	74	63.8
term postion full time hours	1	1.9	2	3.8	1	0.9
term postion part time hours	1	1.9	0	0	1	0.9
casual postion less than full time hours hours	3	5.8	2	3.8	8	6.9
other	-	-	3	5.8	2	1.7
unsure	-	-	3	5.8	-	-

Respondent / Incident	Target		Perpetrator		Non-Target	
	f/% (52/100)		f/% (52/100)		f/% (116/100)	
Position Seniority						
14 days or less	5	9.6	-	-	-	-
15 to 30 days	1	1.9	-	-	-	-
31 to 60 days	-	0	1	1.9	1	0.9
61 to 90 days	3	5.8	0	0	1	0.9
91 days or more	43	82.7	40	76.9	114	98.3
Unsure	-	-	11	21.2	-	-
Shiftwork						
combination of 3 different 8 hour shifts (days, evenings, nights)	28	53.8	25	48.1	70	60.3
combination of 2 different 12 hour shifts (days & nights)	12	23.1	13	25.0	36	31.0
combination of 8 hour and 12 hour shifts	1	1.9	2	3.8	6	5.2
unsure	11	21.2	12	23.1	4	3.4
Area of Nursing [1]						
cancer care	-	-	-	-	2	1.7
clinic/ambulatory	2	3.8	1	1.9	10	8.6
critical care	10	19.2	10	19.2	21	18.1
emergency	3	5.8	6	11.5	10	8.6
geriatric	4	7.7	4	7.7	27	23.3
maternal/newborn	7	13.5	7	13.5	15	12.9
medicine	4	7.7	4	7.7	25	21.6
mental health	-	-	-	-	2	1.7
neurology	1	1.9	1	1.9	1	0.9
oncology	1	1.9	1	1.9	1	0.9
operating room	1	1.9	1	1.9	3	2.6
orthopedics	-	-	-	-	2	1.7
palliative care	-	-	-	-	7	6.0
pediatric care	2	3.8	2	3.8	10	8.6
rehabilitation	1	1.9	1	1.9	5	4.3
surgery	7	13.5	6	11.5	17	14.7
women's health	1	1.9	1	1.9	5	4.3
other	8	15.3	7	13.5	8	6.9
Geographic Region						
Winnipeg	43	82.6	43	82.6	66	57.4
Burntwood	1	1.9	1	1.9	3	2.6
Central	1	1.9	1	1.9	9	7.8
Interlake	2	3.8	2	3.8	2	1.7
Marquette	-	-	-	-	3	2.6
Norman	1	1.9	1	1.9	2	1.7
North Eastman	-	-	-	-	3	2.6
Parkland	-	-	-	-	5	4.3
South Eastman	-	-	-	-	4	3.5
South Westman	-	-	-	-	16	13.9
Westman	-	-	-	-	1	0.9
Unsure	4	7.7	4	7.7	2	1.8

f = frequency % = pecent - = no data

1. Some non-targets indicated they worked in more than one area of nursing.

APPENDIX H

GEOGRAPHICAL MAP